Best Quality
at the
Best Price

PREPARED BY
THE FEDERAL / PROVINCIAL / TERRITORIAL
COMMITTEE OF OFFICIALS (SENIORS)
FOR THE
MINISTERS RESPONSIBLE FOR SENIORS

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QUALITY AT THE BEST PRICE

The following papers representing jurisdictions throughout Canada (Federal, Provincial, Territorial) were developed in response to direction from the Ministers Responsible for Seniors in June 1996. The Ministers decided that Officials should review ways of measuring and achieving high quality service for the best price. This topic is one of three included under the title of Continuing Care. Continuing care in turn is one of several topics concerning the Ministers and their Seniors Officials.

Continuing care is an important issue for the Ministers because the demand for these services, including home care and institutional long-term care will continue to increase with the rising number and proportion of seniors in the population. The growing seniors population is demanding more long-term care and support both from the established service system and informal caregivers such as spouses, children and friends. These informal caregivers provide enormous amounts of care, however, the nature and quantity of the care required often exceeds the capability of the informal caregivers whether they are younger adults or seniors themselves. The combination of growing needs for service and the reality of limited resources require governments to place increasing emphasis on quality and price. This means the purchase or delivery of services at the best price that meets quality expectations of accountable bodies-usually government or coordinating agencies.

There is an increasing recognition in human services that high quality and best price are not mutually exclusive concepts, and if achieved will result in better service for more people. The challenge lies in developing the relationship between the two so that the best possible blend of quality and price is achieved and reflected in the result for the consumer and the system as a whole.

The material in these papers was generated in response to a questionnaire developed by Ontario which served as chair for the continuing care sub-committee for the Committee of Seniors Officials. Each jurisdiction was asked to provide, as comprehensively as possible information about how they ensure that key continuing care services are of high quality and delivered in a cost effective manner. The key services were identified as home care and continuing care facility but respondents were encouraged to include other areas if they wished to do so. The questionnaire was intended as a guide to content rather than a mandatory format for response. For example, under the heading "quality" a number of dimensions were suggested, including professional standards, training requirements financial management requirements, outcome indicators and mandated quality improvement process. Under the heading "best price" it was noted that best price is not the same as lowest price but rather reflects "best buy" or "value for money." These guidelines were followed by nine questions covering processes and mechanisms directed toward best quality and best price including questions on results and evaluation.

The resulting papers portray continuing care as an evolving system across the country, one that is changing in response to societal pressures, yet the change is proactive as well as reactive. The papers reflect creative responses that exceed the demands that are imposed by economic and demographic trends. Although the systems described are very different in some respects there is a great deal of common ground around broad goals and key features of the delivery system. Many of the differences simply reflect the diverse nature of Canada with respect to geography and population distribution. In all cases it is clear that emphasis is placed on concepts such as ease of access for the person requiring assistance, whether through a "one-stop" system or a reduction in duplication accompanied by better

coordination within the continuing care system. These types of changes may benefit both the individual receiving service and impact positively on quality and price.

What follows is not so much a recipe for achieving best quality at the best price, but rather a description of the way various jurisdictions are explicit in their efforts on this area. This is particularly true, as noted above, when quality and price are considered separately. Issues around quality such as legislation, regulation, policy, standards and evaluative efforts are dominant while discussion of innovative approaches to best price are less developed. This may reflect the fact that efforts to link best quality and best price have only come to prominence in the recent past, however it may also suggest that quality is still the dominant factor in the provision of continuing care. In these papers quality is always of prime importance while best price may be dealt with by more standard expenditure control practices.

Over the last four years there have been major changes in Alberta's health system in response to the health reform agenda. This agenda has challenged the health system to be wellness based, consumer focused, integrated, accessible, appropriate and affordable. In November 1996, the Minister of Health announced "Action on Health" initiatives including the Best Practices Review as part of a comprehensive package of initiatives which form the core of the business plan for the Ministry of Health.

Regional Health Authorities (RHAs), Alberta Health, the Provincial Mental Health Advisory Board, the Alberta Cancer Board, physicians, consumers and other key players are all focused on the improvement of health status of both the population and individuals. Alberta Health has recognized that improvement in the overall quality of Alberta's health system requires a new focus on accountability and governance principles as well as a commitment to Best Practices. The Best Practices review is a mechanism to promote continuous improvement through the exchange across Health Authorities of the initiatives, strategies and specific services that are working well. It is the spirit of continuous improvement that links Best Practices to clarity in governance and a focus on accountability.

The Best Practices Review links directly to several of the key directions noted in the current Ministry of Health business plan, specifically: to streamline and simplify the system with reduced duplication and people working together in a coordinated system and to continually improve health through education, leading edge treatments, research, information and technology.

What are the standards?

Standards include:

- Professional standards
- Training requirements
- Human resource requirements
- Financial management requirements
- Organizing/management process requirements
- Mandated quality improvement process

These standards exist in legislation, regulations, policy and clinical practice guidelines.

How were the standards developed?

Standards were developed through the development of regulations and legislation, implemented in the late 80's and early 90's. Stakeholders, professionals and consumers were involved in the process. Revisions are made through policy and regulations. The process involves consultation directly and indirectly with consumers and providers.

How are the standards monitored and enforced?

Many of the current standards are in legislation (ie. Nursing Homes Act and Home Care Regulations) administered under the Minister of Health, and provide the foundation for accountability in the system. Regional Health Authorities have a direct responsibility for ensuring the delivery of a full range of

services to health care consumers. The Minister outlines the provincial standards in legislation and RHAs are responsible for ensuring standards are adhered to and for setting any additional standards in their region. Many RHAs have dedicated staff responsible for ensuring standards and best care practices are evaluated and improved. In case of a violation, the Minister of Health has ultimate power in "inspection" and "enforcement".

Evaluation

Most recently, the results and evaluations of efforts to achieve the highest quality have been captured in the "Best practices, a Report of the Review of Health Authorities Best practices", June, 1997. The report was prepared by consultants who met with regional health authorities, service providers and consumers. This review was conducted in the interest of continual learning and quality improvement in the health system. The New Models in Continuing Care Demonstration Project* (6 projects at 12 sites), up and running since the fall of 1995, is testing and evaluating new models of continuing care. These projects are adult family living, dementia care, integrated community care programs, assisted living, native heritage enrichment and transitional care programs. A University of Alberta Research team was awarded a grant from the Seniors Independence Research Program to evaluate selected demonstration projects.

Best price

Each Regional Health Authority is responsible for ensuring that they are getting appropriate value for their money. There are provincial standards for the health system and the continuing care program. Each RHA, depending on their organizational direction and plan, has its own standards and measures for home care and continuing care. Alberta Health is currently developing a minimum data set for utilization submissions based on standards and measures. Home care already has a standardized set of measures based mostly on supply.

RHAs are responsible for any escalation in costs in continuing care centres or home care. Alberta Health provides a global budget for each RHA, but does not micro-manage the way RHAs provide their services. Similarly there are no Alberta Health processes that ensure substitution of the most cost effective service as this is an RHA responsibility.

The system that Alberta has put into place provides flexibility for individual regions to move resources where they are needed most. Any pricing analysis and decisions are made at the local level. Any central "tinkering" could jeopardize the benefits of a decentralized system.

Alberta Health Innovative Models in Continuing Care

On August 31, 1995, Alberta Health announced that six innovative continuing-care demonstration models, delivered on twelve sites throughout Alberta, would receive funding from the federal government initiative "New Horizons New Models in Continuing Care":

1. Adult Family Living

There are three adult family living projects: Carewest, Calgary; Rimbey, David Thompson Health Authority; and Capital care group, Edmonton. These projects provide a community-based alternative for frail seniors who need assistance with day-to-day living, but who do not require high levels of professional services. The client is offered the option of staying in a private home, where the client receives room, board, individualized daily care and supervision. Professional health services and respite for home operators are offered through partnerships with regional continuing care centres and home care programs, and contracts with private agencies.

2. Alzheimer's Care

- Capital Care Group, McConnell Place North, Edmonton. This program provides care for persons diagnosed with Alzheimer's or related dementia, specifically those at the mid-stage of the disease. The free-standing, residentially oriented facility ensures residents can enjoy maximum independence in safe, secure and pleasant surroundings. Staff are specially trained to deal with the unique needs of this group.

3. Integrated Community Care Programs

- Capital Health Authority, CHOICE Program, Edmonton. Medical, social and other support services are combined to provide a full continuum of care to older people who are frequent users of acute care or who might otherwise be candidates for admission into a continuing-care facility. The goal is to maintain frail older persons in their homes and the community, for as long as possible. At the centre of his initiative is an adult day program. The CHOICE program provides a coordinated approach to health services to allow seniors to remain in their homes, and at the same time benefit from coordinated care. The program increases independence, reduces duplication of services and hospital inpatient stays.

- Cold Lake Health Centre. The client, family, the Cold Lake Health Centre and community work together to develop an integrated plan of care. An aim of the program is to create a seamless continuum of care and a "one-stop shopping" climate for the senior client group. A Senior's Wellness Clinic and education program enhance services currently available to area seniors.

4. Assisted Living

- Good Samaritan Society, Wedman House, Edmonton. Wedman House is a 30-suite residential setting which serves adults who need facility-based continuing care, but don't need constant professional care. This model accesses health, home support and housing services to create an individualized service plan that promotes privacy, dignity, choice, respect for individuality and independence.

5. Native Heritage Enrichment

- J.B. Wood Extended Care Centre, High Prairie. A unit within the J.B. Wood Extended care Centre houses an innovative program specifically designed for the local Métis and Treaty Indian population. It includes traditional native medicine and meals, a Cree interpreter, native heritage decor and culturally-based recreational activities. The program was developed and evolved over time in collaboration with local Aboriginal communities.

6. Transitional (short-term) Care

- Foothills Hospital, Calgary. This project looks at new ways of using continuing-care beds to create more fluid patient movement among the acute community and emergency services. Short-term services include: IV therapy, post-surgical convalescence, palliative care, healthcare education, spousal and family support of residents. This program has focused in two specific client groups: those who require peritoneal dialysis and individuals with altered respiratory function.

- Allen Gray Auxiliary Hospital, Edmonton. This project is designed for those clients who need more rehabilitative and skilled nursing services than can be provided by home care, but who do not need acute-care services. It is specifically designed to prevent admission to acute care and assist clients to return to the community.

- Central Park Lodge, Edmonton. This is a short-term rehabilitation program for older persons who are eligible for early discharge from acute care, particularly those with physical or mental conditions which necessitate a higher level of care and intervention than is available through home care or the community

rehabilitation program.* This program will prevent or delay the need for permanent residence in a continuing-care centre or reduce the length of stay in acute care. It also offers the client the choice and opportunity to receive required rehabilitation services closer to home.

STAR Program, Peace Health Region. The STAR program provides short-term assessment and rehabilitation to individuals who do not require full time admission to a continuing care centre, but have short term needs that exceed the resources available in home care. The program helps to reduce admissions to, and reduce lengths of stay in, acute care.

A final report on the demonstration project will be available early in 1998. Since the beginning of this demonstration project, many more innovative models have been initiated in regional health authorities across the province.

BRITISH COLUMBIA

The former Continuing Care Division (CCD) of the Ministry of Health had a Quality Assurance Branch from 1987-1997 which was responsible for developing, implementing and monitoring program standards for Home Support Services, Adult Day Centres and Residential Care Services (facilities) contracted by the division.

Responsibilities for establishing a process to ensure standards are met and corrective actions are taken when standards are not attained, were devolved to the regional health authorities in April 1997.

Quality

What are the standards?
The standards developed by the Quality Assurance Branch were structural in nature and focused on the five areas of:

- administration
- personnel
- social environment
- care services
- physical environment

What process was used to develop the standards?
A consultative process was used to develop the initial standards. Prior to regionalization the CCD Standards Committee was established to oversee the planning, development, testing and implementation for the revision of standards for the continuing care services funded by the acute and continuing care programs. Six working groups were established to develop revised standards for Case Management, Community Rehabilitative services, Adult Day Centres, Home Support Services, Residential Care Services and Organizational Functions (generic administrative standards).

More than sixty participants representing the British Columbia Association of Community Care, the British Columbia Association of Private Care, the British Columbia Health Association and quality assurance and continuing care staff from the provincial office and field operations throughout the province were actively engaged in the review process.

The framework for development of the revised standards was derived from the core values and beliefs of the former CCD, the principles of continuous quality improvement and the theory of health promotion. Draft values and beliefs statements were developed to provide guidance to the working groups throughout the developmental process. These draft values and beliefs statements were validated, and additional concepts of importance were identified through a province wide stakeholder consultation with 270 clients, families and formal and informal caregivers.

What process exists to ensure standards are met?
Prior to regionalization Provincial and Municipal Quality Assurance Consultants monitored compliance

with facility, home support and adult day program standards throughout the province.

Program standards were developed for home care nursing, rehabilitative services and case management in 1993 and 1994. No formal process was introduced to monitor these standards on a routine basis.

What actions are taken when standards are not attained?
The new program standards are intended as a tool to assist organizations and practitioners to evaluate care and service delivery and the organizational systems which support positive client outcomes. Dimensions of quality addressed include: effectiveness, accessibility, client and staff satisfaction, continuity of care and competence.

What are the results and evaluations of efforts to achieve the highest quality?
A draft document has been completed and pilot testing of the standards for Adult Day Centres, Home Support Services and Residential Care is currently underway. Decisions regarding testing the case management, home care nursing and rehabilitation services standards and implementing the standards in the various services settings will be made following the pilot.

Price

Background
Continuing Care programs in British Columbia consist of contracted/purchased services of Adult Day Centres, Home Support and Residential Care. Case Management, Community Nursing and Rehabilitation services are delivered by the Health Authorities.

Responsibility for local allocation and management of funding provided by the Ministry of Health rests with the local health authorities. Local reallocation decisions are bound by provincial policy which directs that the only changes in funds between service sectors may occur from acute to community.

What process is used to measure and ensure the best price is attained for services?
Both the continuing care funding formulas and standards for purchased services are established in consultation with the industry. Residential Care is also measured against licensing regulations.

Funding formulas include the following parameters. Annualized Residential Care budget adjustments consider pay equity, occupancy levels and resident care levels. A formula based on several factors including utilization rates, population growth and age over 65 is used to determine the annual global funds for Home Support services for each health authority. Funding for Adult Day Centres considers the centre's capacity, the number of days of service and the care level of the client.

Reporting requirements for services include quarterly financial reports (for contracted services) and client classification and workload data reported through a central health information system. This service data is monitored by the province and the health authorities. Continuing Care program philosophy includes such concepts as: individual empowerment and responsibility, minimum intervention, fairness and equity and public accountability. The program is supportive in nature and there is an expectation for families to provide care, where reasonable. The program aims to supplement and complement, but not replace, care provided by individuals, families and communities.

Clients are admitted to Continuing Care Services through a single entry case management process. Clients are screened for eligibility, and clients who have an illness or disability for which a third party is

liable will be referred to the appropriate party.

During the assessment process the case manager is asked to explore possible options and/or alternatives for the provision of required health care services with the client. Case managers assess the client's level of function and support network to determine service need.

An individualized client care plan is developed considering such factors as preference, availability and cost to the Continuing Care program. Case Managers use a standardized tool to assign levels of care. Policy dictates the maximum hours for each level of care, and hours over policy maximum must be approved by a designated senior manager.

Options for care may include appropriate substitution of the most cost-effective service. Clients who wish more control and choice in their lives may opt to be directly funded for their Home Support services. Caregivers may use an Adult Day Centre as a respite option.

Waitlisting for residential care will only be considered when all alternatives have been fully explored and where it is not possible to provide adequate Home Support services. Exceptions require prior approval of the senior manager.

Cost Containment Quality

Cost containment measures consider philosophy and include application of policy and guidelines. Recent regionalization of health care/services, including the Continuing Care programs and services support the philosophy of promoting client independence as "close to home" as possible. Service policy is aimed at providing service which meets client needs within the available funding. Acute and Continuing Care policy dictates that there shall be no shift of funds from the community to acute care.

A minimum of 80% of Continuing Care operating costs is expensed in wages. Reorganizing the provincial bargaining structure for health has significantly reduced the number of collective agreements within the province. Funding for salaries and pay equity is governed by the guidelines of the Public Sector Employer's Council standards and the guideline of the Health Employer's Association of British Columbia.

To contain escalating Home Support costs, a decision was made in January, 1996 to limit the provision of housekeeping services to those clients at least risk. Clients at the lowest level of care are not admitted to the program unless they require personal assistance services.

In addition, clients may not be waitlisted for facility placement until they reach a specified level of care, thus ensuring the more costly residential care service is appropriately utilized.

Service quality is protected by standards and legislative regulation and pursuant monitoring. The health authorities are expected to manage within available resources. Utilization reports are produced and continue to be monitored centrally and in the field.

Capital Costs

The 1997 Report of the Task Force on Public-Private Partnership (P3) concluded that P3 offers the

potential of real and substantial benefits for capital projects. While P3s are not the answer for every capital project, those that offer value for money should be pursued. The task force recommended government demonstrate full support of the P3 initiative through the development of a Ministry, an Advisory Board and implementation of a pilot project experience. The report also recommended a comprehensive policy framework, guidelines for use in planning and budgeting capital projects and development of action plans and procurement guidelines. P3 application criteria are being established currently.

Evaluation

The Office of the Auditor General uses Value for Money audits to assess whether government programs are being implemented and administered in an economic and efficient manner, and whether the government has provided the Legislative Assembly with appropriate accountability information. A Value for Money audit consists of a comparison of actual performance against standard performance. Each audit has an objective, that clearly states what the audit is designed to do; a scope, that establishes the boundary of the audit; and a conclusion, that is in response to the audit objective. Value for Money auditing is based on two principles, first, that public business should be conducted in a way that makes the best possible use of public funds, and second, that people who conduct public business should be accountable for the prudent and effective management of the resources entrusted to them. Such an audit was carried out for the Home Support Program in 1995/96. The audit results were as follows: The Auditor General found the authorities covering the home support program were being satisfactorily complied with, apart from two policy requirements in the Ministry of Health. These requirements were brought to the attention of the Ministry and were rectified immediately.

The measurement of quality and determination of an appropriate value for services delivered will be a focus of Winnipeg Home Care over the next few years. While there is a significant amount of work to be done, there are a number of measures and processes in place across the home care program in Winnipeg. In addition an evaluation framework has been developed for a demonstration project in which a range of services have been contracted to a private home care provider. Information has been prepared to describe the general processes for quality and then more specifically processes related to the contract demonstration project. The directions outlined for Winnipeg Home Care are representative in a general way of approaches throughout the province.

How were the standards developed?

Provincial standards were developed by the Home care branch. The majority of the standards were developed in 1974 and are output and process standards. These standards have recently been revised to reflect the changing role of government in service delivery with the introduction of Regional Health Authorities. The standards were widely circulated in draft form for input from home care providers and the Continuing care Advisory Committee, Home Care is waiting for final approval of the standards.

What are the standards?

Professional and Para-professional protocols
These protocols are provincial. They describe the nature of the care/task, provide a guideline for frequency and the qualification of the care provider. These protocols are used by all agencies who deliver home care services.

Monitoring.

- Protocol Review baseline on all existing cases
- Ongoing supervisory review of cases outside protocol
- Statistical analysis of trends (data base being created)

Case Coordinator Practice Standards
A multidisciplinary task group has developed these standards in draft form. These standards are a first attempt at developing client focused outcome standards. Further refinement of standards and the training around the standards is required before implementation can occur.

Monitoring

- Case review
- Caseload review
- Performance management system
- Complaints management process

Human resources
Standard job descriptions for case coordinators, resource coordinators, registered nurses and licensed

practical nurses are used across the province, although some regional variation may occur. The civil service interview and rating processes are used for recruitment and hiring. Criminal record checks are part of the standards.

Winnipeg Home Care has defined standards and processes in place for hiring of all home care direct service workers. There are standards for orientation of all staff There are also additional training requirements during the orientation phase for all home care attendants to ensure competency in critical personal care skills.

A standardized exit interview is carried out for workers who leave Winnipeg Home Care.

Client satisfaction measures
Client satisfaction is largely determined through the complaints management process and a review of client response.

Financial management requirements
Winnipeg Home care is required to follow the standards and processes of the General manual of Administration for the provincial government.

Monitoring.

- numerous checks intrinsic to the system
- government auditors conduct periodic audits
- audit findings shared with Home Care
- action plans developed and implemented

Organizational and management process requirements
Winnipeg Home care is at the beginning of a provincial regionalisation process and these processes will be developed in the context of the new management structure. There are management processes in place that provide information on indicators of performance including statistical reports, complaints management, incident reporting and various human resource reports.

Winnipeg Home care is planning on expanding an automatic screening assessment and care planning tool that is client focused, developed using a data base format that will generate management reports.

As contracts are being created the format is evolving to include statements that clarify expectation and where possible, anticipated results. The approach taken is one emphasizing partnership involving mutual responsibility and accountability for results.

Monitoring

- reports are reviewed centrally providing information on program delivery

Mandated Quality Improvement Process
Winnipeg Home care will be hiring a quality care coordinator who will work with senior management to develop quality management systems.

Demonstration project.
Home care has contracted the delivery of nursing, personal care attendant and home support services to new clients in a geographic are of Winnipeg. An evaluation of the effectiveness of the contract will be done after one year of experience (May, 1998). The evaluation has two components:

- Evaluation of consumer satisfaction
- Evaluation of organizational efficiency and effectiveness

Both components will use the same dimensions of quality care. The dimensions of consumer satisfaction were developed using information from other jurisdictions and service related businesses and by identifying the critical elements expressed in both the complaints about the program and written thank-you letters. These dimensions are as follows:

- consumer empowerment continuity of care
- staff competence
- quality of care
- training and supervision
- effectiveness of service
- responsiveness

Evaluation of consumer satisfaction
This aspect will be carried out using an external evaluator. Preliminary questions to provide information related to effectiveness in each of these dimensions have been prepared as guidelines for the evaluator. The process will hopefully provide information about the effectiveness and the relative importance of each of the dimensions of each of the dimensions from the perspective of the client. Information from the contract and the non-contract group of clients will be compared.

Evaluation of organizational effectiveness and efficiency
Using the same dimensions described above, we will identify indicators of effectiveness and use a variety of sources of program data to begin to develop a measurement tool that can be used across Winnipeg. The information can then be used to compare districts and to set targets for improved performance.

Personal Care Homes

Until 1991, the standards provided by Manitoba Health to personal care homes were in the form of guidelines developed in areas where the need was greatest.

In addition, standards of the professional associations were emphasized. Guidelines developed included:

Infection Control in Personal Care Homes

- Guidelines for Physicians' Services in Personal Care Homes
- Planning Guide for Personal Care Homes in Manitoba
- Guidelines for Adult Day Care
- Guidelines for Use of Restraints

• Guidelines for Maintenance of Health Record

Where necessary, these have been updated and they continue to be used.

The Regulation under the Public Health Act that governs standards, Regulation 337/88, has long been recognized as inadequate. In 1991, a section of The Health Services Insurance Act was approved allowing Regulations to be written respecting standards of personal care home buildings and care.

How were the standards developed?

In working toward regulated standards, the first step taken was to develop broad standards and criteria which would form the basis of the regulated standards. This document was developed over a three year period with input by all personal care homes, involved government branches and external agencies. It contains standards that are considered mandatory and which are, or will be, regulated; it also contains standards to be worked toward.

Standards for Manitoba's Personal Care Homes and Related Programs was published in 1991. The companion document Standards for Pharmacy Services in Manitoba's Personal Care Homes was published in 1989 followed by the Prescribing Guide.

These documents have since served as a basis for the format of standards visit reports and for the draft regulation.

The next step was to prepare the first draft of the regulation which would replace Regulation 337/88 and contain the mandatory standards. Some of the deficiencies to be corrected are in the following areas:

- ability to withdraw or place conditions on licences
- penalties for non-compliance with mandatory standards
- current building standards including security systems
- Mandatory reporting of critical incidents
- reference to policies approved by the Minister which are mandatory

Monitoring of Standards in Personal Care Homes

Personal care homes, except those juxtaposed to rural hospitals, are monitored by staff of the Long Term Care Branch of Manitoba Health. Standards visits may involve reviews of an entire facility, an area or department, or a particular issue. Consultants representing nursing, pharmacy, dietetics and rehabilitation services may all be involved in a comprehensive facility review or one or two may visit in a limited standards review. A review may take one day or several days spread over a few weeks.

Consultants visit personal care homes for many reasons in addition to inspection or standards visits. These would include:

- complaint follow-up
- staff in-service
- Board meetings

- follow-up of concerns or previously made recommendations
- construction and renovation projects
- financial audits
- planning new programs
- Special circumstances such as a change in Administrator or Director of Nursing

Time is spent on facilities with problems rather than carrying out repetitive surveys of homes that are functioning satisfactorily.

Administrators and/or Department Heads are notified of standards visits as it is essential that the appropriate personnel be available for interviewing and instruction. Reviews of policy manuals, schedules, actual staffing, resident health records, menus, minutes of meetings, and care plans provide a factual basis for the consultants' reviews. Reports and recommendations are sent to the Chief Executive Officer and Board following standards visits and responses indicating actions taken are requested by a specified date.

Many visits are made unannounced or with very short notice. These visits are usually to follow-up on complaints or to discuss specific issues. When the need is indicated, the visit may take place at any time of the day or night and the consultants will speak with whatever staff are available.

- Other mechanisms that are used by Manitoba Health to monitor standards in personal care homes include:

- Other provincial departments and agencies are involved in inspections of personal care homes and will report concerns to the Long Term Care Branch; e.g., Public Health, Fire Commissioners' Office, Workplace Health and Safety.

- Approximately 43 personal care homes are accredited by the Canadian Council on Health Facilities Accreditation. This is a voluntary process but Manitoba Health encourages participation in accreditation and funds the cost of the survey. The facility must pay the annual fee.

- Annually, every personal care home is visited by a nurse assessor from the Long Term Care Branch to monitor the level of care of every resident. Additional information is gathered that provides a picture of care in the facility: number of decubiti, catheters, oxygen, etc. The nurse assessors report their observations.

- Monthly reporting of hours and professional ratio of nursing staff of proprietary personal care homes. If these are not met, payments can be reduced.

- Quarterly financial reporting including actual staffing by non-proprietary personal care homes.

- Regular reporting by psychogeriatric resource teams regarding their input into Winnipeg personal care homes.

- Involvement of Long Term Care Branch staff in educational programs in the personal care homes allows informal feedback and monitoring.

Critical Incidents and Complaints Issues

Long Term Care Branch Protocol:

• Complaints and critical incidents reported to the Long Term Care Branch are documented in memos to file. Depending on the nature and implications, they may be reported to the Director Long Term Care Branch, Assistant Deputy Minister and Deputy Minister/Minister.

• The consultant receiving the complaints or incident report follows up with facility either by phone or by visit, and with family members and/or others if necessary. Actions and follow-up by the facility are documented in memo to file. Any deficiencies not being dealt with e.g., education of staff, need for equipment, change in practices or policies, are following up by meetings and/or written recommendations depending on the situation.

NEW BRUNSWICK

n the past few years, there have been many changes to the Long Term Care system in New Brunswick. Since the release of the Long Term Care Strategy document in 1993, considerable work has been done in an effort to unite and coordinate systems and services which were already in place. Long Term Care refers to a range of personal support, physical and mental health care services required by individuals who, because of long term functional limitations, need assistance to function as independently as possible. Long Term Care involves the partnering of the following divisions of the New Brunswick Department of Health and Community Services: Family and Community Social Services, Institutional Services (Extra-Mural Program and Nursing Home Services) and the Mental Health Division.

Individuals who may be in need of Long Term Care are those people who are dependent, on a long term basis, on a variety of care and services including physical and mental health and community services, as well as residential and institutional services.

There are approximately 18,000 clients age 19 and over receiving Long Term Care Services in New Brunswick. Of these, approximately 10,000 are receiving services at home while 7800 are in residential facilities. Of these, 4000 are in nursing homes.

All clients entering the Long Term Care system go through a standardized assessment process before eligibility is determined. Placement in a residential facility is considered when in-home options are no longer appropriate.

Under the Long Term Care Strategy, there are four types of residential facilities. Types 1 and 2

are regulated by the Family Services Act while some Types 3 and 4 are regulated under the Family Services Act and others under the Nursing Homes Act. Facilities which are regulated by the Family Services Act are commonly known as Residential Facilities. Types 3 and 4 which are regulated by the Nursing Homes Act are generally known as Nursing Homes. Clients with Type 3 or 4 needs requiring twenty-four hour nursing care are placed in nursing homes.

An Operational Liaison Committee has been established comprised of both Departmental members and key stakeholders such as Residential Facility associations, not for profit organizations, advocacy groups and Senior Citizens Federation. The purpose of this committee is to provide a forum for reciprocal communication between the Department and stakeholders, and amongst stakeholders, including input and information on topics related to the day to day delivery of Long Term Care services. This is intended to facilitate working together to ensure the effective use of available resources.

The objectives of the committee are:

• To assist the Department in meeting the needs of people with significant functional limitations who are served through Long Term Care services

• To identify opportunities for service delivery improvements within the framework of the Long term Care Strategy

• To foster sound working relationships in regard to the province's network of Long Term Care services

The first part of this document deals with in-home services and the second part with residential facilities.

Ensuring quality in community services

Overview In-home services in New Brunswick are purchased from a variety of community agencies, both profit and not-for-profit, as well as from private individuals. Purchased services include Homemaker/Home Support Services, Meals on Wheels, Attendant Care, and Respite Care.

Individuals who are receiving in-home support services may also be eligible to receive some professional services such as nursing, physiotherapy or occupational therapy, through the Extra-Mural Program of the appropriate Region Hospital Corporation.

A Single Entry Process approach to services is employed. The Long Term Care assessment may be initiated by contacting any one of the three Long Term Care partners,(Family and Community Social Services (FCSS), Extra-Mural Program (EMP) or Mental Health). Assessment is conducted by both a social worker from FCSS and a health professional from EMP or Mental Health. This is a functional assessment which identifies the applicant's ability to function in his/her own environment, as well as the ability of the informal network to meet their assessed needs. If the applicant is determined eligible for Long Term Care services, a care plan is then developed by the assessors in collaboration with the client. If the recommendation is to provide in-home support services, arrangements are then made for purchase of services from the appropriate service provider. Depending on the type of service required, services are requisitioned by employees

of the Department or, in some cases, the client may make arrangements for the purchase of private services and be reimbursed by the Department to an approved level.

Homemaker/Home support services are the most common services purchased for seniors receiving in-home services. In 1996, the Department of Health and Community Services implemented the Request for Proposal for the purchase of homemaker/home support services. This was done in accordance with changes made to regulations of the Public Purchasing Act. The goal is to ensure best quality service at the best price. Contracts were signed for a one-year period with the option to renew for one additional year in March, 1997. The purpose of the Request for Proposal is to create a qualified list of service provider agencies who have the capability of delivering homemaker services. At the present time, only homemaker services are purchased via the RFP process. There are approximately 40 service provider agencies on the approved vendor list.

Proposal Format
Proposals must contain the following information:

1. Description of the Service Provider Agency including the purpose for which it exists, the structure, length of time in existence, current number of staff and position titles for these staff. A copy of the agency's current Human Resources Policy is to be included.

2. Copy of most recent audited financial statement

3. Description of homemaker services provided including types of service, hours of service, training required for direct service staff and supervisors of direct service staff.

4. All- inclusive price per hour of service

5. Areas of the province in which the service provider agency is willing to provide service

6. Languages in which the service provider agency can provide service.

7. Invitation to tender form

8. Description of services provided at no cost or special services provided to clients of the Department of Health and Community Services

Evaluation

An evaluation committee made up of staff of the Department of Health and Community Services and Department of Supply and Services review the proposals. The Evaluation Committee makes recommendations as to which Service Provider Agencies will be placed on the approved list of vendors. Further information may be sought from certain or all vendors before the final recommendations are made. Final recommendations are made by the Department of Supply and Services after which written notification is sent to the successful Service Provider Agencies.

Homemaker services must be provided as per current standards established by the Department of Health and Community Services. Homemakers are required to have passed the Homemaker/Home Care Worker Training program offered by New Brunswick Community College. Other combinations of training and experience may be considered.

Evaluation of the proposals is based on the information provided plus two references. Agencies must have a minimum score of 80 to be placed on the approved vendor list. Scoring is allocated as shown in the following table.

Item	Possible Score
Stability of Organization	20
Experience in the Homemaker business	20
Acceptable Human Resources Policies (Includes training policies)	20
Cost of Service	20
References	15
Client Support Services provided at no cost	05
Total Score	**100**

Other In-Home Services The RFP process applies only to Homemaker/Home Support services. Other in-home services are purchased through purchase of service contracts. Program standards (currently under review) for Meals on Wheels and Adult Day Care help ensure quality of service. As well, client satisfaction is an indicator of quality service.

Quality in residential services

Overview of residential services

Residential services in New Brunswick are provided through a network of residential facilities which range from Type I through to Type 4. The Residential model of Long Term Care which was implemented in 1997 was designed to ensure a continuum of care for clients of residential facilities. Types 3 and 4 which are generally identified as Nursing Homes are governed by the Nursing Home Act and Regulations. Types 1 through 4 Residential Facilities outside of nursing homes fall under the Family Services Act. This residential component of the long-term care network includes approximately 745 Residential Facilities serving roughly 3800 clients and 61 Nursing Homes, with a total of 4167 beds. Nursing homes provide services to individuals who are assessed as needing Type 3 or Type 4 services, specifically individuals who are medically stable and in need of 24 hour nursing care.

Residential facilities outside of nursing homes are for the most part, privately owned and operated. Others are managed by (not-for-profit or for-profit) boards. All must be licenced by the Department of Health and Community Services in order to accept Long Term Care clients.

In New Brunswick, residential services in nursing homes are provided by agencies which are regulated by government but which are privately owned and operated. All but one of these agencies are not for profit and are operated by volunteer boards of directors.

Ensuring quality in residential facilities

Introduction

Under the Long Term Care Strategy, standards for residential facilities providing services to Long Term Care clients were implemented in 1997. These standards address areas such as mission statement, compliance with laws and regulations, staff qualifications, staff development, staff ratios, environment and security as well as resident care and social environment. The Residential Facility Standards replaced those which had been in existence for special care homes and adult residential facilities other than nursing homes. Residential Facility standards were developed with input from key stakeholder groups.

New Brunswick established the Nursing Homes Act in 1982. This Act, the Regulations under the Act, the standards and the provincial directives provide the minimum standards which nursing homes are expected to comply with. These standards address such areas as the environment in the nursing home, staffing standards including qualifications and ratios, resident services standards such as in dietary, and safety standards. Nursing Home Services is presently reviewing the standards to clarify and improve them. A framework consisting of four areas (leadership, resident services, environmental services and human resources) has been established to assist in this exercise.

Residential Facilities are also expected to comply with other regulatory standards, such as the National Building Code, occupational health and safety requirements, and public health standards. Compliance with these standards is also monitored by others, such as Public Health and the Fire Marshall's Office.

Monitoring Compliance with Standards

Residential Facilities Licensed by Family and Community Social Services

The Family and Community Social Services Division has responsibility to ensure that facilities comply

with the standards. Staff assess applications for Residential Facilities to determine an operator's ability to meet standards and inspect approved facilities to ensure on-going compliance with the standards. Renewal of licences is done on an annual basis.

Role of the Coordinator for Residential Facilities

The role of the coordinator for Residential Facilities can be described as follows:

- recruit adult residential facilities as per need

- assess applications for approval to determine an operator's ability to meet criteria as stipulated under the Family Services Act and appropriate regulations and standards

- process applications from prospective operators of Residential Facilities as per Department's required procedures

- recommend the issuance of the Certificate of Approval by the Minister

- process all applications for admission to Residential Facilities

- inform the prospective case managers, applicants and/or family or guardian of the availability of suitable facilities from which they can make their choice

- assist prospective applicants and/or their guardian to choose the most suitable facility taking into consideration the physical and emotional needs as well as the wishes of the applicant

- inspect all approved facilities to ensure ongoing compliance with standards. At minimum, inspections should be conducted annually

- lialse with appropriate agencies and professionals regarding alternate placements or other relevant matters

- provide information to the public, staff of the Department, and other government departments on Residential Facilities

- investigate all complaints received on the operation of the facility

- conduct formal investigations of facilities

- make recommendations regarding the closure of facilities not meeting standards

- monitor the residents' Comfort and Clothing Allowance

- liaise closely with the local Special Care Home Operators' Association

- liaise with the Department of Human Resource Development

- identify training need of operators, and whenever possible, assist in meeting these needs

• maintain up to date RPSS records

Residential Facilities Licensed as Nursing Homes

In the nursing home sector, the process used to measure compliance with the standards consists of an annual inspection of the nursing home by Liaison Officers from the Nursing Home Services Branch of the Department. The Department has traditionally linked the license renewal with the date of the inspection and is presently moving to a system whereby licenses will be renewed annually on a date that is not necessarily linked to the inspection date.

Role of the Liaison Officers in the Nursing Home Sector

In the nursing home sector, the activities of the Liaison Officers of the Nursing Home Services Branch of the Department include:

• completion of an annual visit to the nursing home to assess compliance with the standards

• follow-up correspondence and visits as necessary to ensure that steps have been taken to address areas of non-compliance

• providing advice and consultation to the nursing homes to assist in achieving compliance

• completion of complaint investigations and follow-up as required

• serving as the primary contact for the nursing homes with the Department for areas such as budget items, planning of renovations that may be necessary in the nursing home, approval of capital equipment and repair grant items, etc.

In addition to the Liaison Officers, other government staff who work with the nursing homes in supporting compliance and in providing quality services to residents include other Nursing Home Services staff, such as the Director, the Assistant Director, the Project Manager and the Program Manager. As well, a number of Departmental consultants in areas such as dietetics, rehabilitation, and construction are available as needed.

Complaint Investigation

Any complaints in residential facilities are investigated by Departmental staff. Any complaint involving suspected physical abuse, sexual abuse, mental cruelty or any combination thereof, is immediately referred to Adult Protection Service. This can lead to the need for a formal investigation which is usually initiated to determine if there is sufficient grounds to close a facility.

Funding in Residential Facilities

Residential services are a non-insured service in New Brunswick. Those individuals with the ability to pay for residential or nursing home services are expected to do so. Government is the payer of last resort. The Standard Family Contribution Toward Long Term Care Services policy, which was implemented April 1, 1997, requires that a financial assessment be completed for any individual requesting government subsidization for Long Term care services.

All residential facilities must provide 24 hour care/supervision. There are differences in level of knowledge and skills required to provide the required care/supervision.

For Type 1 Residential Facilities (RF1), the staff ratio is 1: 10 for 16 hours a day and 1:6 for the remaining 8 hours. Housekeeping, meal preparation, administration, activity/recreation services are done by the same staff that provide the care/supervision.

In Type 2 Residential Facilities (RF2), the staff ratio is 1: 10 for 8 hours a day and 1:4 for the remaining 16 hours. Housekeeping, meal preparation, administration, activity/recreation services are done by the same staff that provides care/supervision.

For Type 3 Residential Facilities (RF3) outside nursing homes, the staff ratio is 1:9 for 8 hours and 1:3 for the remaining 16 hours.

For Type 4 Residential Facilities (RF4) outside nursing homes, the staff ratio is 1:6 for 8 hours of the day; 1:2 for 8 hours and 1:3 for the remaining 8 hours.

Nursing home funding is through subsidization of the residents who have been assessed as needing financial assistance. Standards related to the funding provided to nursing homes are in place. The care funding standard in nursing homes was 2.25 hours of care per resident per 24 hour period. This 2.25 hours included registered nurses, registered nursing assistants and resident attendants. In nursing homes, there is a requirement to have one registered nurse on duty at all times. A care funding review was completed over the summer of 1997 and as a result, the care funding was increased to 2.375 hours of care effective January 1, 1998 and will be increased to 2.5 hours of care effective April 1, 1999.

In addition to the hours of care, nursing homes are funded with additional staffing, for example in the areas of administration, support services, dietetics, and activation.

Some nursing homes which provide services to individuals assessed as needing Type 4 services have established specialized units, which are funded at a higher rate. There are presently four such units, with a fifth one being planned.

Sustaining Quality Services

The goal of the Long Term Care Strategy is to improve quality of service by coordinating Long Term Care services into a system which reflects an appropriate continuum of care ranging from the informal setting where the family and informal network provides or purchases care, to the formal system where support services in the home or residential services may be accessed appropriately in an efficient and effective manner.

In the nursing home sector, to support the sustainment of quality services to nursing home residents, the Department is supporting the nursing homes in the implementation of total quality management, including staff education on TQM, process improvement, and implementation of a system within the nursing home to measure outcomes such as resident and family satisfaction. In addition, a number of initiatives have recently been implemented to support containment of costs while ensuring provision of quality services. These include the quality of service initiative described above, implementation of a higher percentage of nursing staff educated at the registered nursing assistant level, implementation of a computerized care plan, and support for the development and re-definition of nursing staff roles (development of case management role for registered nurses and medication administration by registered nursing assistants). As well, the Department financially supports nursing homes to be accredited with the CCHSA.

Conclusion

The Long Term Care Strategy in New Brunswick is designed to ensure a quality, cost effective continuum of care for New Brunswickers. The Department of Health and Community Services will continue to monitor and evaluate the appropriateness and effectiveness of the strategy as it evolves in order to ensure the best possible services for those with identified long term care needs.

NEWFOUNDLAND AND LABRADOR

In recent years the vision of health has been changing world-wide from an illness to a wellness model of health care. Numerous health reform initiatives have occurred in Newfoundland and Labrador in response to this changing approach to the provision of health services. The key initiatives which impact on continuing care and the attainment of high quality services at best prices are outlined below.

Continuing Care in this province is a system of service delivery rather than a category of service. It is multidimensional involving both health and social services and as such it is an amalgamation of short and long term care in both the community and institutional agencies.

Structural Changes

Effective 1992 virtually all the major categories of continuing care were united into one division within the Community Health Branch of the Department of Health. These included home nursing, physiotherapy and occupational therapy, home support, meals on wheels, respite care, assessment and placement, assessment and treatment centres, day programs and personal care homes. Chronic care and nursing homes come under the Institutions Branch of the Department of Health. Transportation and housing for seniors have remained under the jurisdiction of other departments, while the Seniors Drug Program is a shared responsibility of the Department of Health and the Department of Human Resources and Employment.

Regionalization

Beginning in 1993, the delivery of institutional and community health services has been reorganized under thirteen regional governance structures. These thirteen boards replace thirty-nine previously independent boards. The establishment of regional institutional and community health boards is now complete and all boards are in operation, except the St. John's Nursing Homes Board, which will become operational on April 1, 1998. Reorganization of the long term care facilities in St. John's will continue for the next 2-3 years.

Health reform has also meant bed closures in many acute care settings. Small hospitals in rural areas have undergone role changes and now provide primary acute care services and long term care residential accommodation.

Subsequent to decentralization, Regional Community Health Boards are responsible for the governance and delivery of direct health services in all aspects of continuing care with the exception of the long term care (chronic care beds and nursing homes) which come under the Regional Institutional Boards. Responsibility for funding, day to day operations, and operational and quality assurance, all fall with the regional board mandates.

While Provincial Headquarters of the Department of Health no longer has direct responsibility for the delivery of client services, the Department does retain responsibility for policy direction, resource allocation and monitoring of programs and services. It also has some involvement with the Boards, on a day to day and individual basis, in terms of dealing with concerns and policy issues.

The move to regionalization has improved the effectiveness and efficiency of the governance of

continuing care by moving the organization and management structures closer to the service delivery points. It is also more cost effective e.g. through shared resources and it enables the Department to respond more flexibly to the needs of seniors and their desire to be served closer to home.

Integration of Departments of Health and Human Resources and Employment

Effective April 1, 1998, the Divisions of Child Welfare and Community Corrections, and Family and Rehabilitative Services, currently under the jurisdiction of the Department of Human Resources and Employment, will be integrated with community based programs offered by the Department of Health.

This initiative will provide further improvements in quality and comprehensiveness of service delivery for seniors at better prices than are possible under the present system.

Impacts of this merger will be significant throughout the system as the new Department of Health and Community Services attempts to maintain current operational activities, and at the same time, streamline program and service responsibility in the new entity.

Provincial Housing Strategy

Housing for seniors comes under the Newfoundland and Labrador Housing Corporation (NLHQ and includes such programs as Housing Adaptation for Seniors Independence and the Renovations/Rehabilitation Assistance Program. In 1997 the NLHC took over the Canada Mortgage and Housing Corporation's (CMHQ portfolio in this province. This move will be of financial and quality benefit to seniors as the CMHC housing did not provide any support services (as NLHC does) and CMHC rental was based on near market value, compared to the NLHC policy of rent geared to income.

A provincial housing strategy is now being developed, in consultation with the Departments of Health and Human Resources and Employment, so as to offer an enhanced housing program for seniors, taking their home care needs into account. Housing will still be responsible for the physical structures while the new Department of Health and Community Services will help identify clients and provide information and services to them.

Levels of Care

The Province is currently pilot testing four levels of nursing care in its long term care facilities. Recently some Personal Care Homes, which meet program and design standards, have begun taking level two clients. Long term care institutions primarily accept Level III and IV clients; however, due to design considerations some homes continue to admit Level I and II clients.

Study on Long Term Care Utilization

The St. John's region has approximately 1400 long term care beds in long term care facilities and personal care homes. A study is currently ongoing to evaluate future demands in relation to long term care in this region and the current provision of these services. The study is looking at waiting lists, the number of hospital beds being occupied by clients waiting to be admitted to a long term care facility, as well as matching the needs of the clients and the level of care which they are currently receiving.

Budget

An additional $2,000,000 is being transferred annually from the Institutional Sector to the Community Sector from 1996-97 to 1998-99 in recognition of the shift in focus and service from an acute care to a community based service delivery approach. There has also been a recent increase in the private pay rates for clients of personal care homes , long term care facilities and the home support program.. These rates are currently $900 per month in personal care homes and $2800 per month for long term care facilities and $2268 for the home support program,. A financial assessment is completed prior to admission to determine the client's ability to pay.

Approximate annual budget allocations for continuing care services are:

Long Term Care Beds *(in nursing homes or acute care settings)*	$150,000,000
Personal Care Homes	$6,500,000
Community Care Homes *(identical to Personal Care Homes but clientele is exclusively former residents of the provincial psychiatric institution)*	$2,700,000
Home Care	$13,000,000
Core Programs	$172,200,000

A major initiative in the high quality services for best prices area is the development, in 1997, by the Department of Health, in partnership with the Community Health System, of Core Programs for Community Health. This holistic approach incorporates all community health services under the umbrella of 4 "core programs" overall ie. 1. Promotion and Support of Health and Well Being

2. Promotion of a Healthy Environment

3. Prevention and Control of Communicable Diseases

4. Provision of Health Services

The Core Program Manual, key sections of which are attached, outlines specific goals, objectives, strategies, activities and indicators for the 4 major community health core programs.

Core Program 4 - Provision of Health Services - refers to a comprehensive continuum of community based services in the areas of continuing care and mental health and addictions services. The objectives, strategies, activities and performance indicators for this area (see attached) were developed in consultation with provincial, regional and community representatives.

The integration of Mental Health and Addictions Services into the continuum of care increases emphasis on, and improves the overall quality and cost effectiveness of delivery of continuing care services for

seniors.

As "Core Programs for Community Health" is a new project, evaluation of the approach has not yet begun. It is anticipated, however, that this approach will greatly improve the quality and comprehensiveness of community services provided to the residents of the province, in a timely, more cost effective manner. Initial evaluation, through the implementation of performance indicators, will begin in 1998.

Single Entry System

The single entry system for access to all levels of continuing care was instituted provincially in 1996. Single entry provides equal access, on a regional basis, for all clients to all facets of continuing care. As the care level of the client changes, the single entry system facilitates access to the appropriate service.

Single entry provides an appropriate and cost effective use of community and institutional services through the use of enhanced screening and assessment tools that provide a more appropriate match of client need with service provision.

Client Satisfaction:

Client satisfaction is an important component of CQI and is usually determined by a review of client and/or family complaints. These complaints or bouquets may be conveyed through client satisfaction surveys, resident councils, family meetings, etc. Clients' rights are also formally addressed through the residents council and policies and procedures of the various organizations.

Mandated Quality Improvement Process

Long term care institutions and personal care homes are encouraged to establish quality management programs. These are reviewed as part of ongoing program evaluations by the Regional Boards.

How were standards developed?

The Department of Health, in collaboration with the various stakeholders, has developed policy guidelines and standards for personal care homes and long term care facilities. These Manuals outline specific policies related to the rights of residents, levels of care, building design, administrative policies, resident care policies, as well as policies related to nutritional care and food services, financial management, medication, resident records and sanitation and infection control. The manuals are currently under review.

How are standards monitored/enforced?

The long term care institutions in the province are subject to accreditation by the CCHFA and must meet all the associated accreditation standards.

Personal Care Homes have recently moved to a process of accreditation as opposed to regulation. A Transition Manual was developed in 1996-1997 and the Regional Boards took over responsibility for operationalizing the Manual. Budget cutbacks, however, had an impact on the Boards' abilities to

implement all aspects of the Manual.

Long term care facilities and personal care homes are also subject to various legislative acts including the following:

- *Homes for Special Care Act;*
- *The Hospitals Act.*
- *The Corporations Act*

as well as any other applicable federal/provincial/municipal/corporate legislation under which Homes are licensed: licensure; fire safety; public health; labour guidelines; building codes; sanitation and food handling; health professionals; and the charter of rights.

The Department of Health regulates Long Term Care Facilities and Personal Care Homes pursuant to the Public Health Act. By Order in Council the Minister of Health establishes minimum levels and standards of service for all programs delivered by the Regional Boards including Long Term Care, Personal Care Homes and Home Care.

The Department of Health, with the assistance of the Government Services Centre of the Department of Government Services and Lands, and various health care and financial consultants and auditors, work with the Regional Boards in monitoring the compliance of Long Term Care Institutions and Personal Care Homes with standards and administrative policies on a regular basis. Professional staff review building design and safety issues, resident care and services including pharmacy, dental and mental health services, home environment, nutrition, financial matters, staffing and the administration/operation of the home.

An institution can lose its approval status if there is evidence of failure to comply with building and/or program standards. Unapproved facilities would not be eligible for referrals of clients (all of whom come through a Single Entry System) or for financial assistance by the Regional Boards for client placement.

There are some Regional disparities in the various services; however, there are ongoing efforts to fill these gaps through various consultative processes.

Policy, guidelines and standards are also applied to Home Support Agencies under the policy direction and monitoring of the Regional Community Health Boards and the Department of Health. Licenses are granted, suspended, revoked or renewed based on compliance with provincial standards, as set by the Minister.

Responsibility for the various activities within the Home Support Program varies according to the organizational structure and the funding mechanisms. For example, the Regional Community Health Boards may provide home support services through self-managed care or a contracted agency. Funding for services may be public or private.

Human resources requirements and staffing levels

Human resources requirements and staffing levels are determined by Health Care Boards through their global budgetary process. These allocations are based on provincial and national norms/standards of care ie. accreditation.

For the most part, nursing workload measurement systems have not been utilized in long term care and community settings.

The Provincial MIS Nursing Committee has recently developed a generic template for nursing workload measurement in long term care. This template is currently being piloted in a number of long term care facilities.

Professional standards and training requirements

Professional standards and training requirements for nurses and nursing assistants are determined by the respective professional associations and provincial education/ training bodies. Similarly, home care workers must successfully complete a formal training program (120 hours).

All of the initiatives referred to above are designed to provide high quality service in the most cost effective manner. Additional initiatives in relation to cost control include contracting services from private companies eg. dietary, pharmacy, housekeeping, laundry; shared services, such as laboratory and x-ray and financial administration.

Evaluation

Cost benefit analysis of the initiatives referred to in this paper have not yet been completed as most of these are in the initial stages. That is a long term goal, however, as is overall evaluation of these programs through the implementation of specific performance evaluation techniques.

NORTHWEST TERRITORIES

n responding to the Continuing Care working Group's initiative, on reviewing various jurisdictions' approaches to quality and price, it is important that a brief overview of the administrative and accountability framework of the health & social services delivery system in the NWT be presented. It should be noted that the political, economic, and cultural environments in the North are unique, and not necessarily compatible or comparable with those of the Provinces.

Background

As the NWT Department of Health and Social Services moves out of direct service delivery and into the ministry functions (e.g., monitoring, evaluating and developing standards, legislation and policy), the daily business of both the community/regional Boards and the Department will change.

A series of documents have been developed to facilitate this change, and together these documents lay out the relationship between the Boards and the Department, and clarify the day to day business of both organizations. Boards in the NWT range from those based on a single community to those that represent a dozen communities, and populations range from a few hundred to a few thousand.

Relationship Documents

- Partnership Agreement
- Contribution Agreement
- Accountability Framework

Companion Documents

- Core Services Paper
- Outcomes and Standards
- Formula Allocation Funding
- Health and Social Services Planning and Evaluation Framework

Relationship Documents

The Partnership Agreement, Contribution Agreement and Accountability Framework are collectively referred to as the "relationship documents" because they focus on describing the relationship between the Boards and Department.

Partnership Agreement (also known as the "spirit document")

- Describes the relationship between the Boards and the Department as a partnership.

• Describes the overall goals of the Boards and the Department for the health and social services system.

• Describes the relationship between the Boards and Department by describing the roles that both will play in the health and social services system.

• Provides a broad framework/ understanding for more detailed descriptions of accountability (see Accountability Framework) and funding arrangements (see Contribution Agreement).

The Partnership agreement is signed by both parties, the Boards and the Department, once, and reviewed a minimum of every three years. It may be revisited at any time if one party feels it is necessary.

Contribution Agreement

• Sets the financial relationship between the Department and Boards.

• States how much money each Board will receive, and the services the Boards will provide.

• Sets the reporting requirements and legislated responsibilities regarding funding.

• Lays out the financial reporting requirements that are further described in the Accountability Framework.

The Contribution Agreement is the only document in this series that is signed off yearly.

Accountability Framework

• Tool for both the Boards and the Department to use to clarify specific roles and responsibilities.

• Sets the relationship between the Boards, Department and other stakeholders.

• Describes the health and social services system overall.

• Describes where authority for specific responsibilities such as; public health, child welfare and community corrections comes from.

• Ties the documents together.

The Accountability Framework is a living document that is not signed, and therefore, can be updated as roles and responsibilities change.

Companion Documents

The companion documents guide both the Boards and the Department in their day to day business. The companion documents support the relationship documents in that they describe specific responsibilities of both organizations in the area of planning, development and delivery of services for the NWT.

Core Services Paper

• Provides a means to ensure that the same range of services are provided in a decentralized delivery system.

• Defines the categories of services that must be available and accessible to all residents of the Northwest Territories.

• Sets priorities by defining client groups and areas of health within each core service.

• Provides a framework that is flexible enough to enable Boards to set priorities based on population needs, while protecting the integrity of the system and ensuring the public that they will receive quality programs and services.

• Provides details in terms of Board and Department accountability for provision of core services as identified in the relationship documents.

Outcomes and Standards

• Provides a mechanism for the Department to decide what areas they will monitor and at what level.

• Defines the terms; standard and outcome.

• Defines the level of standards; macro, meso, micro, for categorization.

• Categorizes existing standards.

• Develops broad outcomes for the Department and boards to work towards.

• Adds clarity in terms of Board and Department accountabilities for meeting set standards and working towards common outcomes.

Formula Allocation Funding

• Provides a mechanism for the funding of Boards through a population based funding approach for the delivery of Core Services.

• Adjusts funding according to age, gender, health status and cost difference between regions to allow a more equitable distribution of funds based on demographic information.

• Allows the Boards more flexibility to meet their population's needs while recognizing that there are a fixed amount of resources that must provide services for all residents of the NWT.

Health and Social Services Planning and Evaluation Framework

• Provides the Boards and the Department a process for planning and evaluation.

• Enables the Boards and Department to set up an evaluation process for programs and services that monitors program effectiveness.

• Provides a mechanism for stakeholders to have input into the type and level of services available to the population.

• Provides a framework to inform the public about the services available and the change in health status that has occurred on a yearly basis.

• Sets out the requirements for a health and social services plan, and a framework to evaluate whether programs were effective at meeting the needs of the population.

• Ties funding, core services, and outcomes into a process that aids the Boards in the development of their service delivery model.

Context

For each of the service areas (Long term care - Extended Care Facilities and Seniors' Homes; Group Homes; and Home Care), decisions on the determination of quality and price are being delegated to the Boards. The Boards in turn are responsible for ensuring that the quality standards are adhered to and evaluated, and that the price criteria fall within the block funds allocated by the Department. The Boards, within their allocated funds, are then responsible for determining priorities with respect to service delivery and service provision, reflecting the particular needs of their population. The Department, through the previously mentioned documents, is then able to ensure that the overall goals, financial responsibilities; reporting/legislated requirements, roles and responsibilities and accountability criteria are defined, measured and monitored.

In discussing the above service areas, all of the areas will be treated as one, unless unique or outlying criteria come in to effect. This fits into the Department's action plan for the reform of long term care (LTC) in the NWT through the Care Facilities Reform project. The scope of this project is defined by the following criteria:

a) Review the mandate, goals and objectives of LTC services

b) Describe LTC services in the NWT including client group profiles, and utilization and expenditure information

c) Develop the preferred continuum of LTC services in the NWT

d) Identify potential impacts of LTC reform on LTC services provided in hospital and children's group home settings

e) Develop reporting standards for services and facilities

f) Develop target service levels for services and facilities

g) Develop and implement a single-point-of-entry approach for LTC programs and services

h) Develop and implement plans to reprofile existing and new LTC Facilities

i) Link recent repatriation efforts to LTC reform

Quality of services:

Within the Territories there are a number of formal and informal mechanisms and processes that exist which serve as indicators of quality. A brief explanation of the informal system here will be followed by more detail of the established processes within the Department.

Due to the small population base of the NWT, individuals have greater access to redress complaints at a variety of levels. The Department policy on complaints establishes a process whereby the first point of redress is the facility or program in question, then the Board and then the Department. The culture of the North is such that individuals take ownership of their MLAs, and thus dissatisfaction with services are often directly addressed to politicians and thus find their way to the Department through the Minister in question. This form of consensus government forces the Department to get involved in the discussions that ensue towards addressing the concerns outlined, and provide for an opportunity to revisit decisions on a more regular basis than may be afforded to other larger jurisdictions in the Provinces.

While best practice models do not exist, the function of such models is adequately addressed by the environment here in the NWT. Quality assurance is addressed by the Boards and includes mechanisms such as client satisfaction surveys, Continuous Quality Improvement and Risk Management programs.

What are the Standards?
Given the Board responsibilities for provision of services and accountability of outcomes, it is their role to ensure that the appropriate standards for quality are developed, implemented and evaluated. However, given that these relations between the Department, Board and communities/delivery agencies are new, standards are currently being developed by the Department for each of the areas. These standards are based on a template which captures the following board areas:

- Definition of terms
- Facility/program organization
- Service provision
- Client support
- Human resource management
- Financial resource management
- Information resource management
- Physical resource management
- Program operation
- Any other area that may be specific to the program/facility in question

How were the Standards Developed?
The process for the development of standards generally involves the following stages:

• Development by the Department of a draft based on a template used for standards development within the care facilities reform group

• Consultation amongst the Department staff involved in the areas affected by the standards being developed, e.g., child welfare, information services, financial services, etc.

• Consultation with those involved in the direct service provision, facility and/or program management

• Development of a re-draft based on input from the stakeholders consulted

• A final round of review of the final draft by the stakeholders involved

• Distribution and implementation of the standards

***Outcomes and Standards** (monitoring/evaluation/ongoing standard development)*
The Outcomes and Standards working group has been established to assist the Department in determining key outcomes that should be monitored in order to achieve, via the benchmark of related standards, stated goals and outcomes.

As the Department moves to a ministry role, Its activities will increasingly focus on monitoring and evaluating the health and well-being of the NWT population as well as how the health and social services system (e.g., programs/services, service providers, etc.) addresses the health and social needs of the population.

To facilitate this move to a ministry role, it was determined that a document should be developed which would benefit both the Department and service delivery agents such as Health and Social Services Boards. It will provide the rationale for level of involvement by various stakeholders (i.e., who should be involved and why) in developing, reviewing and/or monitoring different standards. Such a document will also provide the necessary context for identifying key areas of work (re. standards and related policy) and next steps.

The intent of a standards document is to provide the necessary context for all current and future work on standards carried out by the Department, as well as to assist with further defining the ministry role in the area of monitoring and evaluation. In addition, this document will identify how standards relate to and support broad Departmental outcomes.

Reporting Requirements/Health Status Indicators
The Department has developed minimum reporting requirements for the long term care service areas. These occupancy related reports exist in addition to the financial reporting requirements as set out in the Contribution Agreements and in the Accountability Framework document. These reporting requirements, in addition to existing databases enable the Department to monitor the Boards and the outcomes of their practices.

The financial reporting requirements enable the Department to hold the Boards accountable for not only the financial decisions, but to also ensure that the financial decisions reflect positively on the health status of the population, by measuring the health status and comparing these with the range of services that are required to be provided, as outlined in the Core Services Paper.

The migration and admission patterns of the population, linked with the services provided in a region, provide a good indicator of whether services are lacking or existing services are ineffective.

Community Profiles
Individual regions and communities prepare profiles for each of the major client groups, including the specific needs of each group and the approximate size and location of each client group amongst their population. This enables planning for changing needs and provides a mechanism for matching need with the rationale for appropriate substitution for effective services. In the short term it may appear most costly, but has long term price benefits.

Price of services:

Utilization Data
The Department, and now the Boards as well, review utilization data, expenditure data, and catchment areas for facilities providing LTC services. This process facilitates a review of the way programs, services and facilities are funded.

Through the Care Facilities Reform (CFR) project, the mandate to characterize out-of territories services (type and cost) provided to NWT clients, and to determine if/how these services complement those provided within the NWT, helps to keep dollars in the NWT. This also allows the NWT to develop the necessary expertise to deal with such client groups, thus affecting quality by providing a sufficient client base to develop/enhance professional expertise.

Facility Reprofiles
Facility reprofiles by the Department are based on criteria that consider both cost and quality. Critical mass for expertise, and cost of maintaining infrastructure are some of the criteria which are examined in deciding whether to continue operating certain facilities. Facilities under ten beds are currently being reviewed to determine whether the occupancy levels substantiate the operating and maintenance costs of the building, and provide a caseload which addresses the need that the facility exists to serve and ensures that professional staff expertise is maintained in dealing with the client group.

Northern Realities
In the NWT, the policy of "Buying North" as directed by the government, does not necessarily result in the least cost for purchases of services, but does reflect some realities and achieves other necessary objectives. The opportunity, expertise and availability for competition is not as readily accessible to the NWT as it may be in provinces. As a result of this reality, there is a need to not only develop Northern resources and expertise, but to also support such resources in an environment that demands greater outlays due to transportation, utility, and operating costs that are subject to seasonal variations and limitations of access. This does result in initial higher costs in the short run, but in the long run the development of such resources enables the NWT to establish a sustainable source of expertise and resources that are familiar with the unique culture and environment of the North.

Conclusion

The Department, through the Relationship and Companion Documents, seeks to redefine how priorities on resource development and allocation can proceed in the NWT. The intent is to provide the regional and community Boards with the opportunity to be flexible and innovative in provision and delivery of services to their population. Through the block funding, which will initially be based on historic

expenditures, Boards will then have the ability to adapt services and programs in a manner to reflect the unique needs of the communities with which they are most familiar.

Along with this delegation of allocation and accountability criteria, the determination of costs and quality of services will also lay with the Boards. While the Department continues to monitor and evaluate the outcomes with respect to improvement of health status, the Boards have the flexibility of determining delivery models.

While this process is currently underway, the Boards and the Department have still to come to agreement before signing of the documents. Whether accepted or not, the current work and realities still exist and other externalities may still come into play. The planned division of the Territories in 1999, to the Western Arctic and Nunavut, may affect determination of price and quality in ways that we may not have foreseen.

NOVA SCOTIA

There are a number of ways in which Home Care Nova Scotia strives to ensure the highest possible quality of service delivery at the best possible price.

The program has a Coordinator of Continuing Quality Management (CQM), whose primary accountability is "to ensure that home care is available on an equitable, effective and efficient manner across the province."

The Coordinator: CQM, along with representatives for all four health regions, program policy and planning staff, and care providers from all sectors, developed and implemented a Provincial Quality Management Team, whose responsibility includes:

- Determination of indicators of the principle functions of the Program
- Determination of the measurable criteria and frequencies for monitoring each function
- The method for improvement of performance in areas where there are deficiencies
- The methods for acknowledging individuals and areas where performance expectations are exceeded
- The set up of Regional CQM committees
- The Risk Management activities of the Program

The primary focus of the team for the coming year is the development of provincial and regional indicators and outcome measures.

Each health region has its own Regional Quality Management Team, with a mandate to monitor and address quality management issues from the region. Additionally, every agency or organization providing care to home care clients is required to form its own agency quality management team. There is a reporting cycle and a process which require each Agency's Quality Coordinator to report to the Regional QM team which , in turn, reports to the provincial team. The provincial team summary reports are circulated back to the regions and agencies.

What are the standards?

The standards are intended to describe what is expected of an agency to meet Home Care Nova Scotia's standard. The standards are comprehensive and include such areas as Staff Qualifications, Human Resources, Quality Management/ Continuing Quality Improvement and Finance among others.

How were the standards developed?

Program standards are described in the document Standards for Quality Services Delivered to Home Care Nova Scotia Clients. The standards, developed in 1996, are based on similar standards in other provinces. Edition 1 of the document was developed with wide participation and input from all users and providers in the home care process including:

- Nurses
- Licensed Practical Nurses
- Home support workers
- Professional associations
- Home Care Nova Scotia (supervisors and staff)
- Regional Home Care Directors

A second edition was prepared reflecting input from participants in the first document, as well as wide input from all agencies (nursing and home support) who received the document and are expected to comply with the standards. A third edition of the document will reflect changes recommended from the same groups and major input from the auditors whose task is to visit care provider agencies and organizations to audit compliance with the standards. The new document will contain new standards (e.g. Partnership Development and resource management) and new groupings of standards (Administration, Staffing, Education and Training, Policies and Procedures, Service Delivery, Partnerships and Quality Management).

How are the standards monitored/enforced?

A process for auditing compliance with the standards was developed, modelled after the provincial Long Term Care licensing process and the national accreditation process of the Canadian Council on Health Services Accreditation. Currently, about 90% of all service providers have been audited, and results have been very favourable. The audit for compliance is done about every six months (half of the standards are audited each time). Any standard with a questionable or non-compliant rating may be audited at any time at the discretion of the auditor or the Program.

Best price

The Program's policies state that at all times, care must be provided by the lowest level of qualified care provider. This means care is not to be provided by a Registered Nurse if the care activity is approved to be performed by a Licensed Practical Nurse. The same is true for activities done by an LPN if the activity is approved to be performed by a Home Support Worker. In addition an approved task list is part of the Program Policy Manual (currently under review). The list describes all the activities involved in the provision of home care, from personal care activities to complex nursing functions, and indicates which level or levels of care provider may perform them. A regular review of every assessor's caseload includes an evaluation of whether the tasks are being provided by the lowest level of approved care provider. For example, a client with a dressing will have an assessment to determine whether the dressing must still be done by the RN, or if an LPN can do it.

Client satisfaction was measured shortly after the Program began. Also work has begun by the Provincial Quality management team to develop a standard satisfaction survey for clients and care providers.

Long Term Care

(Nursing Homes and Homes for the Aged)

Quality
What are the Standards?

There are professional standards, e.g., a registered nurse on duty in each home 24 hours a day. There are no specific training requirements, however, the department supports a Personal Care Worker (PCW) Advisory Committee which works to provide training to personal care workers in nursing homes. This training has a defined "scope of practice" for trainees. The department supports an Alzheimer and Related Dementia and Education Program currently available in the province for facility staff. There are human resource requirements such as minimum staffing levels for direct care. Staffing standards are currently under review.

The department approves each facilities budget and per diem on an annual basis. Annual budget information and audited financial statements are required from each facility. The department performs personal use allowance fund audits in a number of facilities each year.

There are organizational and management process requirements for facilities.

The annual inspection and licensing process reviews a number of issues. Although there are no formal outcome indicators at this time, indicators will be developed in the future as the inspection function matures.

There is no formal quality improvement process, but many homes have their own quality improvement process and are at various stages in outcome measures. About 20 of 69 long term care facilities are accredited.

How were the standards developed?

The Homes for Special Care Act and Regulations are the framework for overall standards in nursing homes and homes for the aged. Other policies and guidelines exist for the program. The program was under the authority of the Department of Community Services prior to April 1, 1993.

How are the standards monitored/enforced?

The department does address complaints from residents family members, etc. when they cannot be resolved by the facility.

The key process for ensuring standards are met is an inspection and licensing process carried out annually by the Department of Health.

If facilities do not adhere to standards they risk losing their license, however, the department works with facilities to address deficiencies.

Evaluation of Quality

The inspection and licensing function was transferred to the Department of Health in fall 1996. Efforts to

enhance the department's review of quality matters are in progress.

Best price

As noted above each facility's budget is reviewed annually and the budget and per diem are approved by the Department of Health. Per diem rates in Nova Scotia are among the lowest in Canada (average $92). There have been modest increases in the long term care budget in the last three years. Facility budgets have increased in response to the most urgent cost pressures. Fire Marshal requirements and direct care staffing have been allocated the majority of new funding. Given the physical plant and the need for overall program review in nursing homes and homes for the aged in Nova Scotia, it is anticipated that additional funding will be required to ensure a quality program in the coming years. Current methods for setting budgets and ensuring financial accountability will be reviewed.

It should be noted that the Departments of Health and Community services are discussing the concept of a single entry point assessment process to a continuum of continuing care services. This approach, among other benefits, also offers the best opportunity to ensure the substitution of the most cost effective service within continuing care programs. As programming and budget methodology adjustments evolve along with the single entry point assessment, a greater emphasis on formalized evaluation is likely to occur.

Long-term care in Ontario includes almost 2,700 agencies involved in delivery of community and facility services to elderly people, adults with physical disabilities and people who need health services at home. The first part of this paper deals with long-term care facilities (approx. 500) while the second part relates to community based services (approx. 1200) with a primary focus on 43 Community Care Access Agencies which serve as a point of entry for those requiring services such as nursing and homemaking.

Long-term care services affect people who need supports to maintain their daily lives, whether at home or in a facility.

Long-term care facilities are defined as nursing homes and homes for the aged, i.e., provincially funded care facilities.

The government has recognized for some time that changes to the long-term care system are necessary in view of

- Changing population health care needs;
- The increasing elderly population;
- Public expectations for the delivery of quality services in the most efficient manner; and
- The high cost of institutional care.

Ensuring quality in long-term care facilities

Introduction

The monitoring and evaluation of facility care and services to ensure quality care is a process that has been underway in Ontario for over twenty years. The process has evolved from a very intrusive and sanction oriented process to a process of monitoring that is much more collaborative and consultative.

Facility representatives and other interested parties have actively participated in the development of standards and guidelines which have given them ownership and buy-in to the program. Routine compliance review has been separated from the enforcement function which has resulted in a positive constructive partnership with the majority of homes. On the other hand for those facilities that have performed poorly, a consistent, objective and focused enforcement program has ensured that positive results are achieved or sanctions applied as necessary.

Ontario has 56,607 beds in 496 facilities (325 nursing homes, 99 municipal homes for the aged and 69 charitable homes for the aged).

Given that all these facilities serve a common resident population, one of the first steps in the reform of the long-term care system was to bring together the nursing home and home for the aged programs under the Ministry of Health.

The Ministry of Health now has full responsibility for administration of a common long-term care facility program for both sectors.

The provincial government provides funds to support the operation of long-term care facilities.

In return, long-term care facilities are expected to provide resident care, programs and services in keeping with the standards established by the Government.

What are the provincial standards?

Provincial standards are divided into two broad categories - operational and structural.

These standards are contained in the relevant long-term care facility legislation (i.e., the three different Acts) and the Long-Term Care Facility Program Manual. The Ontario Red Tape Commission is proposing consolidation of the legislation into one Act.

Long-term care facilities are expected to comply with the provisions of the respective legislation for each category of home (nursing home, municipal home or charitable home).

Under the service agreement, facilities are expected to take reasonable steps to meet compliance with the standards set out in the Long-Term Care Facility Program Manual.

How were standards developed?

Facility representatives and other interested parties have actively participated in the development of standards and guidelines which have given them ownership and buy-in to the program.

LTC Facility Program Standards Committee

Purpose:
The LTC Facility Program Standards committee is responsible for addressing specific standards, criteria, procedures and protocols in the LTC Facility Program Manual which have direct impact on LTC facility delivery of resident care, programs and services. One key role of the committee is to assist in the clarification, interpretation and application of standards in LTC facilities. Committee membership consists of representatives of the Ministry of Health Long-Term-Care Division and provincial provider associations representing both for-profit and not-for-profit facilities.

The main functions of the committee are:

- To provide a forum for the development of new standards and criteria for The LTC Facility Program Manual.

- To provide a forum for the revision of current standards and criteria in the Long-Term Care Facility Program Manual.

- To review the current accountability approach.

• To provide an opportunity for dialogue and exchange of ideas between the provider associations and the LTC Division on the LTC facility monitoring and review process as set out in the LTC facility Program Manual.

• To develop suggestions for enhancing and promoting an outcome-focused approach to compliance with the LTC facility program Manual

LTC Facility Manual Advisory Support Group

Purpose:
The LTC Facility Manual Advisory Support group is an advisory committee which has the responsibility of reviewing both proposed changes to standards or additions to standards which are specific to the LTC Facility Program Manual.

This committee provides an opportunity for submission of comments and discussion of the LTC Program Manual from all affected parties, meaning, labour, provider and consumer groups.

Mandate
1. To provide a forum for consultation and discussion on the LTC Facility Program Manual for consumer, provider and labour organizations involved in the delivery of LTC facility services.

2. To review and provide comment on proposed changes/amendments to the Facility Program Manual.

3. As needed, to provide an opportunity for committee members to participate in smaller work groups that may be established to revise, refine and/or develop long-term care facility standards.

4. As needed, and on request from the LTC Division, to provide comments to the Ministry on proposed policy changes related to the LTC Facility Program Manual that impact on their respective organizations and/or interests.

How are resident safeguards/ quality of care controls/standards monitored and enforced

In order to protect and ensure the quality of services, the legislation governing long-term care facilities includes provisions for:

• The appointment of Ministry inspectors to monitor and evaluate standards of care, investigate complaints and apply sanctions as necessary

• Resident safeguards, including a Residents' Bill of Rights, to support quality care; and

• Requirements for internal facility quality management programs.

By legislation, long-term care facilities are required to sign a Service Agreement with the Ministry which sets out the operational expectations along with the facility budget. Facilities must comply with requirements of the Act, regulations and Facility Manual standards.

On at least an annual basis, Compliance Advisors (registered nurses) from the Long-Term Care Division will complete a thorough review of resident care, programs and services in each long-term care facility. If non-compliance with the Ministry established standards of care is noted, the facility is given written notice to implement remedial measures. There are regular follow-ups conducted to monitor corrective actions taken.

Complaint investigations also serve to monitor a home's performance and all complaints are investigated. Complaints of a serious nature are investigated immediately by Long-Term Care Division staff.

When a home does not meet the requirements contained in either the legislation/regulations, or policy, various actions are available to the Ministry to enforce corrective action and improvement in service, including application of legislated sanctions where continued noncompliance is identified.

The sanctions include withholding funding under the terms of the Service Agreement, stopping admissions, taking over the operation of a facility, revoking the license and prosecution. It should be noted that all sanctions are not available for each type of facility (nursing home, charitable or municipal home for the aged). The Ministry is taking steps to rectify this situation at present.

Role of Compliance Advisors and other government staff

Compliance Advisor activities include:

• Completion of a thorough review of care, programs, and services on an annual basis (3 - 5 day process);

• Follow-up visits to ensure steps have been taken to correct any deficiencies noted from the annual review.

• Close monitoring of problematic/non-compliant facilities;

• Providing advice and consultation to facilities to assist in achieving compliance;

• Liaison with facility residents, staff and families;

• Completion of complaint investigations and follow up as required;

• Production of public reports;

• Facilitating public meetings as required; and

• Recommending the transfer of homes which are not achieving expected outcomes to the enforcement unit.

Other government staff

In addition to the compliance advisors, other government employees involved in ensuring quality care

include:

Enforcement Officers who visit facilities on an as needed basis by request from compliance advisors or senior management. They are involved for example, in pre-license and pre-sale inspections, investigations of serious complaints or in special circumstances, such as renovations, that might jeopardize resident health and safety. Facilities with issues that require resolution are subject to a more intensive review until those issues are resolved. This review could lead to actions such as suspension of admissions or prosecution.

Planning coordinators review concept drawings and blueprints for facility construction for structural compliance with legislated standards.

Specialized consultants for nutritional care, medical care, finance, environmental health and nursing share their specialized expertise relative to long-term care facilities with facility and government staff.

Complaint investigation

Purpose:

• To provide the public with a means to register issues and concerns respecting the operation of long-term care facilities.

• To determine if a complaint is verified, and if so, determine if there is non- compliance with provincial standards.

• Where a complaint is verified, to determine in consultation with the facility, a plan of corrective action.

Processing complaints:

• As a general rule, the facility is not notified of the investigation (the complaint investigation may form part of another review).

• All complaints, regardless of source and including those received anonymously, are investigated.

• Complainants' names are kept confidential.

How does the resident classification system work towards ensuring best price for services provided by facilities?

Funding overview
The LTC funding formula consists of three envelopes as follows:

Nursing and Personal Care
The funding formula for long-term care facilities is needs based. The key to this approach is the Levels of Care classification system used to determine the funding required to provide the nursing and personal care required by residents of a facility. Ontario uses the classification system developed by Alberta for this purpose. The per diem amount depends on the home's residents' care requirements as measured

annually by the Province (funding for nursing and personal care is higher in homes with residents who need more care and lower in homes where residents are assessed as needing lower levels of care).

The funds cover: salaries of nursing and personal care staffing (registered nurses including director of care, registered practical nurses, health care aides and ward clerks) and expenditures for nursing care equipment and supplies.

If you can't prove you spent it, the Province takes it back.

Programming
Funding is a fixed amount set by the Ministry.

The salaries of program and resident support services staff e.g. physio, activation, social work.

Expenditures for programming equipment and supplies.

If you can't prove you spent it, the Province takes it back.

Accommodation
Salaries of administrative (includes administrator) and environmental services staff dietary.

"Hotel" costs, for example, maintenance of the building, purchase of furnishings, and cleaning supplies.

$4.38 per day available for food costs which Province takes back if not spent.

Other accommodation amounts can be retained by the facility if not spent (profit) if quality standards are met.

Recruitment, Training, and Collection of Information
Simply stated, Registered Nurses with long-term care experience are recruited and trained as classifiers to collect information and complete the Ontario Resident Classification Form (RCF), a questionnaire that includes the eight indicators of care differences.

Data is collected by the classifiers from documentation maintained by the facilities on each resident. Incidental charting and quarterly summaries support resident care plans. Confusing or incomplete facility documentation is clarified by the classifier with facility staff caring for the residents.

Reliability of Data Collectors (Classifiers)
Reliability of the classifiers is ensured through testing in the use of the tool. Registered Nurses must achieve a reliability score of 90% during training and throughout classification.

Audits

Audits and Appeals were introduced following the 1996 Classification to further ensure reliability in facility documentation and in the collection of data by the classifiers. Auditors reclassified a sample of residents who were classified in the annual classification, and they also classified the same residents based on the care provided that they observed. A comparison of the annual results and audited results was then analyzed. There were 25 appeals but there were no discrepancies significant enough to warrant

a change in funding.

Analysis of facility and provincial results

When all data is collected on the 55,000 plus residents of the Province's long-term care facilities, a computerized system determines the following information:

Resident Information based on Classification
Based on the level of dependence, or differences, in each of the eight indicators, residents are placed into a level of care.

The combination of indicators of care determines the classification of each resident: A and B represent light care; C, D and E represent medium care and F and G represent heavy care.

Facility and Provincial Information based on Classification
When all residents in a facility have been classified, a facility Case Mix Measure (CMM) and a facility Case Mix Index (CMI) are determined.

The Case Mix Measure of a facility is reflective of the care levels of all the residents of a single facility. As well, a Provincial Case Mix Measure is created from the classification levels of all 55,000 plus residents of the province.

The Case Mix Index for a facility is then calculated by comparing the facility Case Mix Measure against the Provincial Case Mix Measure.

Finally, the Case Mix Index of each facility is used to calculate funding for the nursing and personal care portion of the funding formula.

Fluctuations in annual classification results

Since the 1995 classification, very few facilities have experienced a change of more than 10% in their Case Mix Measure and resulting Case Mix Index. This fact was verified with the introduction this year of Audits and Appeals. Only 18 facilities of the 500 facilities in Ontario were entitled to an appeal based on the criteria of a CMM decrease of greater than eight percent (>8%) from the 1995 Classification to the 1996 Classification.

Facility care levels will not stay constant or will continue to increase from one year to the next. Annual classifications reflect current care requirements of long-term care populations providing an equitable base for funding care requirements until the next classification.

As long-term care facilities continue to take in heavier-care residents, the annual Provincial Case Mix Measure - as a barometer of care requirements of all 55,000 plus residents - continues to increase. The Provincial CMM has proven to be an accurate reflection of the increase in care in Ontario from the Provincial CMM of 75.64 in 1992 to the most recent 1996 Provincial CMM of 79.63.

Conclusion

The measures outlined above have allowed the province to develop quality standards in conjunction with key stakeholders, as well as instituting a primarily collaborative approach to ensuring quality care. At the same time a funding system that is primarily needs based ensures that available resources are allocated *where they are most needed as dictated* by the care requirements of the residents. In this case the "best buy" or "best price" means funding that approximates care needs as closely as possible and is adequate in the Province's view to ensure quality requirements are met.

Ensuring quality in key community services

Introduction

In Ontario responsibility for ensuring that continuing care services delivered in the community reflect the goals of high quality and cost effectiveness rests with 43 local agencies known as Community Care Access Centres (CCACs). These agencies are becoming operational in 1997 as a key element in the overall reform of long-term care services in Ontario.

CCACs are responsible for contracting private sector and not-for-profit organizations to deliver services such as nursing, homemaking/personal support, social work and various therapies (occupational, physio, speech). Further, the CCAC arranges through contract for the medical supplies and equipment associated with its community services. Eligibility for entry into long-term care facilities is determined by staff of the CCAC.

The mechanism for ensuring best quality at a cost effective price is a Request for Proposal (RFP) process developed by the Province in partnership with service providers and other interested parties. Generally an RFP is required for professional and homemaking services and when the possibility for the development of innovative and cost effective models for service delivery exists. On the other hand a straight tendering approach generally would be used for specific items, such as standard equipment or supplies, when there is little scope for creativity.

Under the RFP process, there will be equal opportunity for for-profit and not-for-profit agencies to compete for service contracts in an environment of "managed" competition. There is a three-year transition period which will allow some providers to adjust to a competitive environment as they did not have to compete in the old system. During this transitional period, certain measures related to provider volume guarantees will be used in concert with the RFP process to ensure stability and continuity of client services in the LTC community sector.

By April 1, 1999, when the three-year transition protections end, CCACs will be required to use the RFP process for a minimum of 90% of their purchase of service budget. Any single service contract equal to, or greater than, $100,000 must be contracted through an RFP. The RFP process will ensure:

- Provincial consistency
- The promotion of fairness in awarding contracts
- A focus on quality
- A move toward greater cost effectiveness

The Province has developed and distributed a template for the RFP as well as Provincial Requirements

for the RFP process. The template is designed to help CCACs prepare an RFP for services. The policies and principles outlined in the requirements are intended to ensure that the RFP process is effective in achieving best quality at the best price.

Both service providers and consumers were consulted in the development of the RFP process including specific discussion and input about quality issues and indicators of quality.

Quality principles

The quality requirements and principles developed by the Province are for the use of CCACs in preparing RFPs, and by service providers in preparing their response to an RFR. In addition, the requirements and principles will be used by CCACs as part of a continuous quality improvement process, wherein the CCAC will assist service providers to examine their own processes and to implement improvements. At every phase of the RFP process CCACs and service providers must consider three quality principles:

Client Services
Service providers will be expected to continuously improve the processes which enhance service delivery to their clients. Service will be guided by a client-focused approach that respects client choice and evaluates client satisfaction on an ongoing basis.

(Addresses issues including quality improvement process, client satisfaction, respect for client individuality, personal and cultural beliefs).

Human Resources and Financial Management
The organization must have adequate human and physical resources and financial management systems that function appropriately to meet its stated goals and objectives. (Addresses issues including professional standards, staff satisfaction and recognition, staff training; productivity, adequate financial controls/procedures).

Organization
The organization's purpose or mission statement, structure and functions commit the organization to a consumer oriented approach to service delivery. (Addresses issues including organizational planning, risk management, client abuse protocols, client confidentiality).

Assuring Quality Requirements Are Met
For each of the three quality principles there is a list of quality requirements. The approach is to define the requirement while letting those responsible for meeting the requirement determine how compliance is to be achieved. For example, "The service provider has a process for receiving, tracking and following up on client complaints with respect to conflict resolution". It is clear what is expected, but the "how" is left to the provider. Some requirements are mandatory and must be met for the proposal to qualify for consideration. Other requirements are not mandatory, but failure to meet these will affect scoring of the proposal.

Service providers are required to have systems and procedures in place that enable them to measure and correct performance which falls short of requirements.

CCACs must monitor service delivery on an ongoing basis and provide feedback to providers on their

performance. The intent is to ensure that high quality services are provided throughout the term of the contract and that all conditions of the contract are met. Breach of the provisions of the contract may result in cancellation of the contract.

Cost Effectiveness The RFP process encourages a value for money approach to awarding service contracts. This means that the "best" price is not necessarily the lowest price. Quality and other considerations are weighted in a manner that is intended to lead to the choice of the provider with the highest quality at the best price.

Information systems and cost-effectiveness

Information systems are being developed that will allow tracking and comparison of costs over time and among areas. It will be possible after allowing for geographic or other variables to identify significant variations from the norm.

How are prices calculated?
As part of the RFP process, respondents are given specific instructions when developing price quotations for professional and homemaking services.

Professional services

Separate quotations must be provided for different services (e.g., a therapy provider should provide different quotations for occupational therapy, physiotherapy, etc.) and for staff with different professional qualifications (e.g., Registered nurse/Registered practical nurse). Respondents may supply different quotations in response to CCAC requirements for varying levels of expertise, varying types/degree of geographic coverage. After supplying other information related to units of service and indirect/direct service costs respondents calculate the net price per unit of service.

Homemaking service

A similar process to the above is applied to the calculation of the price for homemaking service. One significant difference is that respondents are required to specify average homemaker compensation per unit of service. The total price minus homemaker compensation becomes the net rate. The intent of this calculation is that service providers should be competitive on costs other than those attributable to front-line compensation during the transition period.

How is funding related to anticipated service volume?

A funding methodology was introduced in 1994/95 to allocate new long-term care community resources to districts across the Province. Funding is allocated by Home Care Districts, which enables District Health Councils (DHCs) to plan for the delivery of community-based services in their areas. This funding model helps ensure that finite resources are allocated in a consistent and fair manner throughout the Province.

Allocation of funds through the Equity Funding Formula is based on relative need as measured and defined by the three factors that best explain the distribution of community long-term care services:

• demographic patterns, by 5-year age groups and gender;

• provincial average age-sex weighted resource utilization patterns in provincial Home Care programs; and

• the existing amount of funding used for community services in a district.

Areas that are below average in terms of existing funding in relation to need receive a proportionate share of any new resources. Areas above their need entitlement do not share in funds allocated to equity.

Evaluating respondents' proposals

Evaluation of proposals is conducted by a proposal review committee formed by the CCAC. There are five steps in the selection and proposal review process. These are as follows:

Step 1

Review of respondent's proposal for compliance with mandatory requirements. These are reviewed on a yes/no basis and are not scored. The CCAC will develop mandatory quality requirements that must be met by respondents.

Step 2

Review of respondent's proposal with respect to general requirements. Failure to meet any of these requirements would not disqualify a proposal but would affect scoring.

Step 3

Review of quality of respondent's proposal with respect to clarity and completeness and general presentation.

Step 4

Weighting. Weights are used to assign a relative importance to each evaluation criteria These weights reflect the importance of the criteria. The respondent is made aware of the relative weights and is urged to take these into account when developing the proposal. An example would be as follows:

General requirements	20%
Quality and credibility of the proposal	20%
Personnel	15%
References	10%
Financial viability and stability	25%
Price quotation	10%
Total:	**100**

Step 5

Evaluation of formal presentation made by short-listed respondents. These presentations may be required at the discretion of the CCAC. In addition short-listed respondents may be interviewed by the CCAC, provide a tour of facilities, demonstrate equipment processes, programs and procedures, provide further technical information or additional general information prior to final selection.

Evaluation of the RFP Process

The Long-Term Care Division, CCACs and providers will participate in the further development of the monitoring process, including the development of tools to assist in the process. This task is most appropriately undertaken once CCACs and providers have gained some experience with the RFP process.

Conclusion

The RFP process described offers the potential to maximize quality and price in an open and competitive market. The evaluative and monitoring components at the level of service provider, CCAC and the Province will provide the basis for continuous quality improvement at all levels. The system is very new in Ontario and it is anticipated that the process will evolve and improve over time as more experience with this new approach is gained. However, this evolution will continue to embody quality considerations and a client-focused approach as its foundation. The model demonstrates that considerations of price/cost effectiveness and quality are not mutually exclusive when cost effectiveness allows for fairer allocation of funds where they are most needed at the level of client, provider and contracting body.

PRINCE EDWARD ISLAND

P.E.I., through a project called the Seniors Assessment Program and the work of the Department of Health and Social services, has reviewed and updated services to seniors as part of larger health reform initiatives. The review of services used the five "best practices" as identified in the research of Hollander and Angus (for Health Canada and Seniors Directorate, 1994) as a framework during the implementation of the Seniors Assessment program and the provincial review of services.

The 1994-97 provincial review of services focused on the following:

• Development of a Community and Continuing Care Screening Tool to identify needs, services, support and risks

• Achievement of a consistent assessment and referral process across the community and continuing care sector implementing a coordinated system entry for Home Care Support and Long-Term Care

• Developing a consistent admission and placement process with priority criteria for nursing home care beds in both the public and private sectors.

Outcomes of the review included:

• Single management regional structures that can direct, manage and integrate community, home care, and long term care services, as well as access to financial and welfare assistance.

• Coordinated system entry was developed and piloted through the Seniors Assessment Program, and implemented in all regions for seniors and adults with special needs across the community and continuing care sector.

• The Screening Assessment Tool was developed, tested and implemented in all regions for long term care, acute care discharge for seniors and home care support services.

• Levels of care designations were reviewed and updated using the Screening Assessment Tool.

• Work has begun on the case management process and care coordination as applied to seniors, particularly in home care services.

Quality

P.E.I., as mentioned above, has focused on implementing "best practices" to ensure that a system framework exists that will encourage the allocation of services and funding in an effective manner. The following are brief descriptions of the main features of the system.

Coordinated System Entry

• Coordinated System Entry means that one call or contact will allow access to information and/or service from the P.E.I. health and community service system.

• The initial implementation of this one stop access has been targeted to seniors services such as Long Term Care Placement, Home Care Support, and Acute Care Discharge. When the access system is running smoothly the next step would be to make this type of system entry available to other groups (e.g., adults with special needs, chronic care, physically handicapped and the mentally challenged).

The Coordinated System Entry process is based in the Home Care Support Program, and provides:

1) Access to Services for medically discharged clients at risk of readmission

2) Support or maintenance for seniors declining and at risk of institutionalization

3) Support or respite for caregivers to seniors who need a break, support, or rest in order to continue to provide the primary care in the home

4) Placement service for seniors.

There are five criteria for the Coordinated System Entry process:

1. One call to one phone number will connect the senior to the appropriate information or services across the continuing care services system.

2. As far as the senior is concerned, this call can access a consistent and appropriate screening, the required needs and risks assessment, as well as required referral service.

3. All appropriate options for support and maintenance through community support, or development, and Home Care Support Program are reviewed and utilized.

4. There is a Placement or Admission Committee in each Region to prioritize nursing home bed placement requests and expedite the wait list management. (The Regional Placement Committee/team represents Acute Care Discharge, Long Term Care, Home Care, and collaborate with housing, community and related private sectors (community care facilities, private nursing homes).

5. Requests and stated preferences from the senior are considered a priority.

Eligibility for services and the identification of needs, supports, services and probable risks are

determined through a Screening Tool and Assessment process. The Seniors Assessment Program has developed, implemented, tested and revised a Screening Tool to identify needs for services, support and appropriate placement parameters (May 1996).

After the screening and assessment process a care plan is developed. Staff collaborate with family and the senior to coordinate the care services and supports as required.

The Home Care Support Program

The Provincial Plan developed by the Health and Community services Agency recognized that the Home Care Support program must be prepared to adapt and manage its significant role in a reformed health system. The Program is available to all eligible residents of the province as part of provincial health care

services.

The Home Care Support Program of P.E.I. provides assessment and care planning to medically stable individuals and defined groups with special needs who, without the support of the formal care system, are at risk of being unable to stay in their own home, or unable to return home. Home care provides assistance and support for individuals to cope, adapt, and manage within the range of acceptable risk and safety as identified by the assessment process. Home care services have measurable outcomes and are time limited (4 hrs. per day/28 hrs per week).

Services offered through the Program include:

Assessment - The identification of needs, supports and risks and determination of admission eligibility.

Care Coordination - Provides care planning and case management.

Support services - Includes
a) personal care

b) respite care and services

c) environmental (support to enable support and professional services to be effective and safe) adult protection (investigation, assessment, assistance, intervention, referral)

e) community support (assistance to client and family in identifying and accessing community services, identify and/or assist with local community development or maintaining service and supports).

Professional and Consultative Services - As identified through the assessment and expected outcome process

Services are accessed through the Coordinated System Entry which is managed through the Home Care Support Services Sector.

Since September of 1995, the Program has grouped clients according to the duration and type of service they require. These groups are Short Term Care, Intermediate Care, Continuing Care and Special Needs or Specialized Services. The last group have needs that exceed normal policies, exceed average costs and/or require a specialized resource base (e.g., palliative care, dialysis). This grouping allows the Program to allocate resources to those areas it sees as its primary focus; specifically Short term Care (target is 10% of resources), Continuing Care and Special Needs/Specialized Services.

Care Coordination
Services that are normally available in all regions through the Home care Support Program will be part of the care plan and coordinated by a designated regional Home Care staff.

Referral services that may be required to provide specialized or additional assessment and service expertise as part of the

Home Care Support Program are:

• Nursing

• Occupational Therapy

• Homemaker Support

• Adult Protection

• Community Support (referrals to services available in the community through organizations or individuals (e.g., church group, meals-on-wheels, day care).

• Referrals to physicians are arranged by the family physician. Physician referral, coordination or monitoring is required for admission to short term placement for convalescent, restorative or palliative care.

Case Management

Services that are determined to be required and necessary for the client to be able to stay in the Home Care Support Program, and will have to be arranged and coordinated across other program/service areas in the region/province) will often require a higher degree of time commitment, consultation, financial assessment and authorization.

These more complex high needs and service intense cases that will involve interagency services will usually be assigned to a person in each region with specific case management skills and authority.

Referrals to professional services that may be required for specialized or additional service expertise from other regional programs and services are:

• Physiotherapy

• Mental Health

• Nutrition Dietetics

• Speech and Language Pathology and Therapy

• Social Work

• Financial Assistance

• Audiology

• Pharmacy

• Alternate or Additional Placement Services that can also be coordinated through the system include:

• Community Care Facilities (privately owned and operated establishments with five or more residents. The target population is semi-dependent (seniors, physically or mentally disabled adults) people, who may require supervision for safety and security, as well as the provision of personal care and

socialization.

- In-facility respite care (a planned program of short term relief for the recipient and/or the caregiver).

- Convalescent care services (requires physician referral and coordination).

- Restorative care services (refers to a strategy for best possible recovery or restoration of function, stamina or activation, requires physician referral and coordination).

Palliative care services (active total care offered to a person and his/her significant others living with a progressive life threatening illness, requires physician referral and coordination).

Admission to Service process (community service/nursing home)

Nursing Homes

In P.E.I., there are 946 nursing home beds (396 of these are in the private sector). In addition, to supplement these beds and to provide residential care options for seniors, there are 737 community care facility beds. Seniors occupy approximately 500 of these beds. In each region there are designated person(s) trained and authorized to complete the assessment process for a nursing home admission/placement. The assessment includes the health needs assessment, the level of care, the high risk priority and the type of bed required (level of care, male/female, safety environment, semi/private).

Screening Tool

The Screening Tool: Community/ Continuing Care (Copyrighted - Prince Edward Island: March 1997 - Health and Community Services, all rights reserved) was developed between 1994 and 1996. The tool measurement indicators were standardized by an inter-rater reliability process and then tested and fine tuned through three regional pilot projects. Training and implementation of this tool was completed in 1996 for Home Care admission, Acute Care discharge and Long term care admission and placement.

The Screening Tool is divided into 10 sections for screening, assessment, rating or measurement, function, cognition, home management, self-rated health, risk potential summary , levels of care, client grouping, caregiver availability and skill, as well as the amount or units of service(s) proposed.

The Screening Tool is designed to determine the type of setting and service requirements that are most appropriate for the patient/client.

The Province of Saskatchewan introduced a comprehensive home care program in 1978 through the Department of Social Services. Responsibility for home care was transferred to the Department of Health in 1983, and home care districts were operational by 1984.

The Home Care Act was passed in 1986, whereby grants to fund home care non-profit corporations were made under the authority of the Act. The Health Districts Act passed in 1993, provides authority for the current not-for-profit district health boards to plan, administer and deliver home-based services. The Department of Health does not deliver home care services, rather the District Health Boards are responsible for the delivery of all home care services within their jurisdiction.

Home Care helps people who need supportive, palliative and acute care to remain independent at home. Home Care encourages and supports assistance provided by the family and/or community. Home care services are accessible to any resident of Saskatchewan on the basis of need as determined by an established assessment process. No referrals from a professional caregiver are required.

District health boards are responsible for planning, administering and delivering core health services which include home-based services, in accordance with the Health Districts Act and provincial policies.

Home Care is guided by the following key principles:

people can usually retain greater independence and control over their lives in their own homes than in a care facility;

• support usually provided by families and friends should be encouraged and preserved and, if necessary, supplemented;

• service decisions in Home Care should be based on assessed client need;

• service should assist individuals and families to retain maximum independence and avoid unnecessary dependencies;

• individuals and their supporters should help identify their needs, establish goals, and develop plans to meet goals;

• Home Care should respect a person's right to live at risk and to accept or refuse services; and,

• Home Care programs should participate in planning and coordinating local health and social services.

Quality

How were the standards developed?

Home care standards were developed in collaboration with the former Non-profit home care boards prior to the establishment of health districts in the province. A substantive review of the standards is being undertaken with input from district health boards and other directly affected stakeholders.

What are the standards?

Comprehensive standards have been established for the provision of home care. These include professional service delivery standards, training requirements and outcome indicators. Specifically, home care standards have been developed for the following areas:

- assessment and care coordination;
- nursing;
- homemaking service;
- home maintenance;
- meal service;
- management; and,
- outcome.

The Saskatchewan *Home Care Act*, the Health Districts Act, and Home Care Policy Manuals define the way in which home care programs function, including policies and standards that must be adhered to.

Current home care policies and procedures are contained in the following:

- Home Care Policy Manual;
- Home Care Policy Supplement;
- Home Care Nursing Manual;
- Home Care Information Systems Manual;
- Assessment and Care Coordination Binder; and,
- Guidelines for Developing a Volunteer Program.

A number of initiatives exist to support caregivers including:

- development of a "Wellness for the Caregiver Home Study" by Saskatchewan Health, in response to requests from the public. The Wellness for the Caregiver Home Study focuses on helping the individual explore the needs, challenges, rewards and opportunities of caregiving; and,
- provision of "Guidelines for developing an integrated Palliative Care Service." This was done in consultation with the Saskatchewan Palliative Care Association and other groups. The document promotes providing care at

home whenever possible, and emphasizes such areas as appropriate symptom management and support

for family caregivers.

How are standards monitored/enforced?.

To ensure standards are being met, a set of initiatives have been or soon will be implemented, including the following. A self-evaluation tool is being developed to provide a basis for health districts to ensure quality standards are being maintained. Some health districts currently are undergoing a district wide accreditation of their operations including home care services. This accreditation process is encouraged by Health but is not mandatory. In addition, each health district has a quality of care co-ordinator whose primary responsibilities include assisting health consumers with specific concerns. The co-ordinator will assist in matching individual needs with appropriate services, and ensuring individuals are well informed of their rights and options. As well, home care consumers can appeal care decisions to the district health board. The province is in the process of developing a set of performance indicators which should assist in indicating the quality of care individuals receive.

District health boards are expected to monitor their own home care programs. If standards are not being met, the Department takes steps to address and resolve the issues with the appropriate district health board.

There has not been a recent provincial evaluation of the home care program, however, district health boards are expected to evaluate their home care programs every 3 years. Some health districts have completed an evaluation of their operations, including home care service provision. The Health Services Utilization and Research Commission (HSURC) is undertaking a major study of home care, entailing an examination of the cost effectiveness of the program.

Price

Saskatchewan Health does not contract with the private sector to provide home care services, rather the Department funds district health boards for home care based on population demographics. District health boards almost always deliver home care services directly, however, they have the authority to contract services through the private sector should they so choose.

Home Care funds are allocated by Saskatchewan Health on a per capita basis to district health boards using the district population, adjusted for age, gender, needs indicators, and a special cost adjustment. The adjustment for age and gender recognizes those districts which have an elderly female population (69% of home care services are used by elderly female residents). The needs indicator refers to living arrangements. For home-based services, those districts which have more seniors living alone or living with family members are recognized. For home-based services there is a cost variation adjustment which recognizes large and sparsely populated districts.

There is no upper limit on the amount of home care services that a client can receive, however, many district health boards monitor the costs of home care services and when these costs approach the level of institutionalized services an evaluation occurs to determine whether the provision of home-based services is the best option, or whether the client's needs would be better met in another way, such as a special-care home.

With the recent provincial health renewal initiatives, the provincial home care budget has increased approximately 114% between 1991-92 and 1996-97. District health boards control home care costs by providing services based on assessed need, and by usually giving priority for services to those most in

need and to those most at risk of institutionalization, illness, or Injury.

Special-care Homes

Description

Special-care Homes are facilities licensed under the Housing and Special-care Homes Act, 1966, and corresponding Regulations. The Department of Health does not deliver special-care home services, rather these services are delivered either directly through district health board operations, or through affiliates of the health board. Special-care Homes are funded by district health boards through government funding. The Act and Regulations are under review during the Fall of 1997.

A special-care home is a facility which provides institutional long term care services to meet the needs of individuals usually having heavy care needs that cannot appropriately be met in the community. Special-care homes may be referred to as nursing homes. Special-care homes provide an environment in which individuals can achieve and maintain as high a level of independence and life satisfaction as possible.

Individuals are deemed eligible for residence in a special-care home, and are admitted, based on assessed need when their needs can no longer be met in the community. Facilities are expected to admit clients based on District Co-ordinating Committee (DCC) recommendations on priority of need.

Most districts have a single-point entry system whereby individuals are admitted to special-care homes on the basis of need. That is, the individual with the greatest need is offered the first bed available. In most cases, if the first bed available is not in the facility of choice of the individual, they are given the option to move to the facility of choice when a bed becomes available there.

Saskatchewan is in the process of introducing a new home-based assessment tool (the Saskatchewan Client Information Profile "SCIP"). The SCIP is used to assess individuals requesting or requiring supportive services who reside in a community setting such as a house, apartment, or personal care home. The individual may be in hospital when the assessment begins. The SCIP is used to identify individuals', and their support system's needs and strengths. The care plan is developed from the SCIP with priority given to supporting the individual to live independently as much as possible in the community. SCIP may also identify a need for placement when the person can no longer live in the community.

The special-care homes program is available to those meeting the eligibility criteria for the program. Seniors (92.7%) are the major beneficiaries of the program. Within this seniors group, approximately 69.2% are women. Special-care home charges are income-tested.

Intended impacts on seniors of the program include the provision of a safe environment, safe and adequate care, and a quality of life for seniors, where needs cannot be met in the community, the restoration and/or maintenance of residents at an optimal level of functioning, and the provision of community outreach programs, such as adult day programs, adult night programs, and respite care.

Quality

How were the standards developed?

Standards for special-care homes have been developed in collaboration with special-care home administrators and other affected stakeholders. Standards currently are in the process of being revised to better reflect the current district health board structure. The standards address the following areas:

What are the standards?

Administration standards:

- including such issues as resident rights, staff health requirements, quality assurance, infection control, and occupational health and safety;

Resident Care and Records:

- including such issues as care plans, and feeding a resident;

Medications:

- including such issues as pharmacy services;

Activities/Volunteers:

- including such issues as physician services, diagnostic services, social services, and pastoral care programs;

Food service:

- including such issues as nutritional care, menus, food preparation, and sanitation and safety;

Physical Environment:

- including such issues as fire safety, laundry services, and maintenance services; and,

Community Outreach Programs:

- including such issues as adult day programs, and respite programs.

Specific program principles have been established and are conveyed in a set of resident rights and responsibilities which include the following:

Residents:

- being fully informed of services available in the home and corresponding charges;

- receiving respectful treatment and protection from injury from any source;

- receiving care from qualified personnel and having access to management to discuss issues which may arise;

- expecting personal possessions to be respected and kept safe;

- to comply with the home's policies and practices and to be considerate of the rights of others; and,

- to maintain personal independence and to contribute to the development of a community for all within the home.

Special-care homes:

- to expect residents and visitors to conduct themselves according to the home's policies and practices;

- to inform residents of policies and conditions and to provide current information regarding charges and terms of payments;

- to ensure respectful treatment of residents and to maintain personal freedoms and dignity of residents;

- to protect residents from any foreseeable harm and to protect the property of residents; and,

- to facilitate the establishment of a resident interest group if residents so desire.

How are standards monitored/enforced?

Special-care homes are required to be licensed by Saskatchewan Health. However, routine inspections of special-care homes by Department staff does not occur as often as in the past. Rather, the current expectation is that quality of care be monitored primarily by the district health boards. Inspections by Department staff have been done most recently on the request of the district health board or, if deemed necessary, subsequent to complaints received by the Department. Every effort is made to provide consultation on matters of concern to specific facilities, district health boards or department staff. Prior to the establishment of district health boards, the Department had developed a self-assessment guide for special-care homes, which they are still encouraged to use.

District health boards are expected to provide a Quality of Care Co-ordinator to assist health consumers with specific concerns and to develop policies, procedures and mechanisms to improve the quality of care in the health services of the district. Concerns regarding quality of care are to be directed to management of the facility. If resolution is not obtained, the concern is to be directed to the district health board. Final recourse would be to Saskatchewan Health.

Although current legislation does not require accreditation, district-wide accreditation has the potential to address areas of mutual concern to the Department and health districts. The Department also is looking at other mechanisms to ensure quality, such as peer review and performance indicators.

Traditionally, Saskatchewan Health has not applied sanctions where standards are not met. Instead, the Department has made recommendations as to the need for improvement and have been available to assist in effecting the necessary changes. Time frames for response to the recommendations were given.

A recent provincial evaluation of the special-care homes program has not been done. However, as indicated above, district health boards encourage special-care home administrators to complete a self-assessment guide on a regular basis.

Price

Saskatchewan Health does not fund individual special-care home facilities, nor does it fund on a case mix approach. Rather, district health boards are funded on a population needs-based formula for the provision of

institutional supportive services. Funds are allocated on a per capita basis to district health boards, using the district population, adjusted for age, gender, and needs indicators. District health boards may use a case mix approach to fund facilities within their jurisdiction, however, the boards are not required to use this approach.

Using 1997-98 figures, $259.1 million was budgeted provincially for care in special-care homes. Approximately $95 million in charges are collected annually by district health boards from special-care home residents.

In an effort to best use special-care home resources, health district boards currently admit individuals to special-care homes only if the individual's needs can not be met through community or home based approaches, usually individuals with heavy care needs. Those urgently requiring admission are prioritized. Over the past 4 to 5 years, funding for home care services has substantially increased so that more individuals can have their needs met at home, and thereby delay the need for institutionalization. Due to the Department's increased emphasis toward community based care, some light care facilities have been phased out of service since 1991/92.

Personal Care Homes

Description

The Personal Care Homes Program was proclaimed and established through *The Personal Care Homes Act* and associated Regulations on October 1, 1991.

Personal care homes are privately owned and operated by individuals or corporations with no public funding. Personal care home licensees provide accommodation, meals, and assistance or supervision with personal care to adults aged 18 and over who reside in the personal care home. Personal care and health services are determined through assessment by the District Health Board. Personal care homes can accommodate up to 40 individuals. Most residents in personal care homes are seniors (90%). Personal care homes provide a community option for individuals typically with light care needs. Residents in personal care homes have the same access to home care and health services as other people. Saskatchewan Health provides annual licensing, regular inspections, complaint investigations, and monitoring of personal care homes.

Quality

How were the standards developed?

The *Personal Care Homes Act* and Regulations were developed in a response to many consumer, health and social interest groups that had demanded the private care homes be regulated and monitored to ensure safe and adequate care.

Through annual licensing of the homes and under the relevant Act and Regulations, these homes are required to ensure the delivery of quality care, and to adhere to the standards and guidelines specified in the Act, the associated Regulations and the Licensee's Handbook. Anyone wishing to become the licensee of a personal care home, must complete the licensing process and meet the requirements of the Act, Regulations and Handbook.

In the Act, stipulations are set out pertaining to licensing, inspections, documentation, information requests, reviews of licensing, waivers and exemptions, regulations and penalties. These directives, in conjunction with the personal care homes Regulations, constitute a comprehensive set of standards, terms and conditions under which personal care homes and their respective licensees must operate.

What are the standards?

The current Regulations include stipulations pertaining to:

- requirements for a personal care home license;
- service meeting clients assessed needs;
- record keeping;
- Client assessment at least every two years;
- standards for service agreements with clients;
- standards of resident care;
- staffing levels;
- procedures for medication;
- food safety, nutrition and variety;
- rights and privileges of residents;
- physical environment (building and fire code; health and safety); and,
- fire prevention.

The Licensee's Handbook provides information to prospective and existing licensees on all aspects of operating and managing a personal care home. The Handbook provides an overview of the following broad areas:

- resident care component including medications;
- administration agreement;
- food preparation;
- resident records;
- physical requirements; and,
- staffing expectations.

Specific program principles have been established and are conveyed in a set of resident rights and privileges which include the following:

• to be treated with respect, dignity, kindness and consideration in all interactions with staff, residents and other persons who reside in the home;

• to voice concerns or recommend changes in the rules or services provided in the home;

• to register complaints to the licensee and, if desired, to the minister;

• to attend religious services or activities of the resident's choosing;

• to be provided with personal privacy;

• to have sole use of his or her own possessions unless the resident gives permission for others to use those possessions;

• to receive visitors privately at the home between the hours of 9 a.m. and 9 p.m. without giving prior notice to the licensee;

• to communicate within the home by telephone or mail in private;

• to leave and return to the home as desired at all reasonable hours on notifying the licensee or the licensee's designate;

• to be free from any actions from the licensee or staff of a punitive nature, including physical punishment, threats of any kind, intimidation, verbal, mental or emotional abuse or confinement; and

• to choose his or her own medical, optometric, or other health care professional.

How are standards monitored/enforced?

To ensure standards are met, personal care homes are monitored and inspected on a regular basis which may include inspections without advance notice. Although the province is divided into about 30 health districts which are mandated to administer most health services, all regulation, monitoring and inspections for the personal care home portfolio currently are done at the provincial level.

In addition, Saskatchewan Health has developed a self-evaluation tool for personal care home licensees. This evaluation tool provides an opportunity for home licensees to ensure their home meets standards prior to receiving a licensing renewal.

In the event of non-compliance to established standards and conditions, allowance for legal action and the levying of fines are explicitly stated in the Act. Saskatchewan Health has a mandate to revoke personal care home licenses when conditions of non-compliance are evident.

There has not been a recent overall evaluation of the personal care homes program in Saskatchewan, however, all homes are individually inspected by Department consultants on a frequent basis. A broad review of personal care home regulations, entailing consultations with stakeholder groups, was recently completed and resulted in

substantive changes to the regulations. The licensing process for the homes was also recently reviewed and revised.

Price

The Province does not fund personal care homes. Government retains only a regulatory, monitoring, and inspection role in this portfolio. Residents are required to pay for the costs of accommodation and services in these homes through their own resources. Standards have been established which stipulate conditions forming the basis of admission agreements between home licensees and residents, and the setting of resident fees which are not regulated. All home licensees are required to complete an admission agreement with each prospective resident.

VETERANS AFFAIRS CANADA

The development of standards of quality for services delivered in home care involves the review of other federal, provincial and community agency standards along with a review of literature and professional journals. Internal sources of information include the audits and reviews of current programs and consultations with the front line staff involved in the program delivery.

Professional standards
VAC's approach to service delivery involves a multi-disciplinary team with the roles of each member clearly defined. The members include administrative support staff, counselors, nurses, occupational therapists and physicians. Protocols are established for determining when consultation or referrals are necessary. The standards of the professional groups are first defined within the provincial legislation or association dictates, and secondly within the operating standards of VAC.

Training
The training requirements of professionals are determined similarly to the professional standards. Training requirements established by the province for the profession must be met by the individual. In addition, VAC establishes both broad national and individual training plans to meet departmental standards for client screening and program delivery.

Client Satisfaction
The level of client satisfaction is determined by formal contact with the client through corporate surveys, focus and advisory groups, and by internal monitoring of standardized follow-up, case management and appeals.

Human Resources
The needs of the majority of VAC clients are shifting with their increasing age. The evolution of the programs to meet these changing needs has also resulted in a need to change the role, approach and composition of the staff in the service delivery offices. The varying levels of provincial programs across the country also impact the staff/client ratios. The staff requirements are determined by role definition, national testing of workload and client ratio standards.

Financial, Organizational and Management Process
The establishment of standards for service delivery, turn around times and financial reporting are established for ongoing programs. The effectiveness of the responsibility centre is judged against the standard.

Development projects are managed through a project team reporting to senior management through a steering committee. The process involves the development of the project by the team with testing at selected sites and then further refinement of the program.

Continuing care

The provision of long-term care to the majority of VAC clients is through the purchase of services from provincial or private care facilities. Consequently, VAC does not have standards for these beds, but rather uses those established by the province in which the facility is located. In the case of facilities where an agreement

between VAC and a province designates the use of specific beds for the exclusive use of veterans, any requirements in excess of those specified by the province are included in the agreement.

VAC also carries out audits of contract facilities and verifies that the facility is appropriately accredited.

A less formal method of monitoring service delivery is the tracking and reacting to complaints from clients. When concerns are raised over the level of service being provided to a client, VAC normally works with the province/facility to rectify the problem.